



MINISTRY OF HEALTH AND
MINISTRY RESPONSIBLE FOR SENIORS



2000/2001
ANNUAL
PERFORMANCE
REPORT

National Library of Canada Cataloguing in Publication Data

British Columbia. Ministry of Health and Ministry

Responsible for Seniors.

Annual performance report : 2000-2001.

Annual.

Also available on the Internet.

Report year ends Mar. '01st.

Continues: British Columbia. Ministry of Health
and Ministry Responsible for Seniors. Annual report.

ISSN 1203-6036.

ISSN 1199-0750 : Annual performance report : British
Columbia. Ministry of Health and Ministry Responsible for Seniors.

1. British Columbia. Ministry of Health and Ministry
Responsible for Seniors. Periodicals. 2. Public health.

British Columbia. Periodicals. 3. Medicine. State.

British Columbia. Periodicals. 4. Aged. Government

policy. British Columbia. Periodicals. I. Title.

RA185 B7B74

173.6 C9711 O5

C2001 940179 1

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Office of the Minister of Health Services and
Office of the Minister of Health Planning
Parliament Buildings
Victoria, British Columbia

June 7, 2001

The Honourable Garde Gardom, Q.C.
Lieutenant-Governor of the Province of British Columbia

May it please your Honour:

The annual performance report of the Ministry of Health and
Ministry Responsible for Seniors for 2000/2001 is herewith
respectfully submitted.

Colin Hansen
Minister of Health Services

Sindi Hawkins
Minister of Health Planning

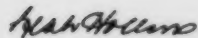
Ministry of Health Services and
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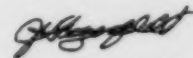
The Honourable Colin Hansen, Minister of Health Services
The Honourable Sindi Hawkins, Minister of Health Planning
Victoria, British Columbia

Ministers:

We have the honour of submitting the annual performance
report of the Ministry of Health and Ministry Responsible
for Seniors for 2000/2001.



Leah Hollins
Deputy Minister of Health Services



John Tegenfeldt
Deputy Minister of Health Planning

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DEPUTY MINISTERS' MESSAGE

We are pleased to present this annual performance report of the Ministry of Health and Ministry Responsible for Seniors for the fiscal year 2000/2001.

This report conforms to the new reporting requirements of B.C.'s *Budget Transparency and Accountability Act*. As the new title – Annual Performance Report – reflects, this is the first Ministry of Health annual report to contain a section on the achievements of the ministry and the health system in meeting key performance indicators. The report also describes how the ministry has met the goals of its strategic directions for 2000/2001.

Measuring our performance gives us the feedback that will enable the ministry to provide increasingly effective leadership to the health system. Supporting improved health for all British Columbians and delivering the quality health services they need are increasingly complex responsibilities. We must set clear goals and measure our achievements to meet those responsibilities.

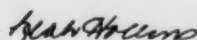
During the past year, ensuring the delivery of timely, quality health services in British Columbia was a challenge for the ministry and the health system – a challenge that is shared by the rest of Canada, North America and the world.

Keeping our health system supplied with doctors, nurses and other care providers where they are needed is proving to be a critical, complicated issue. B.C. is competing with the rest of the world for a limited pool of educated health professionals and we need to create working environments that will attract them and keep them in our province.

Like health systems in other provinces and countries, British Columbia's health system is challenged to meet the needs of our aging population. Continuing to support many of the health care needs of older persons through hospitals and care facilities is not a sustainable solution, nor is it one that serves all seniors well. We need to develop innovative ways of meeting their increasing requirements for support and care that is responsive to and respectful of seniors.

Meeting these challenges requires building stronger partnerships among the ministry, health authorities and key stakeholders, and finding new and more effective ways of delivering the high quality and accessible health care people need. This report shows the work the ministry has undertaken to address all of these areas in 2000/2001.

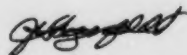
On June 5, 2001, the Ministry of Health and Ministry Responsible for Seniors was reorganized into two new ministries to meet these challenges and to enhance health care in British Columbia. The Ministry of Health Services



Leah Hollins
Deputy Minister of Health Services

provides funding, strategic direction and leadership to support the delivery of health care, preventive health and health promotion services in British Columbia. The Ministry of Health Planning supports the development of long-term planning necessary to sustain B.C.'s public health care system in future years.

In the year ahead, we are committed to continue providing the leadership and support that is needed to create better health and better health care for British Columbians.



John Tegenfeldt
Deputy Minister of Health Planning





INTRODUCTION

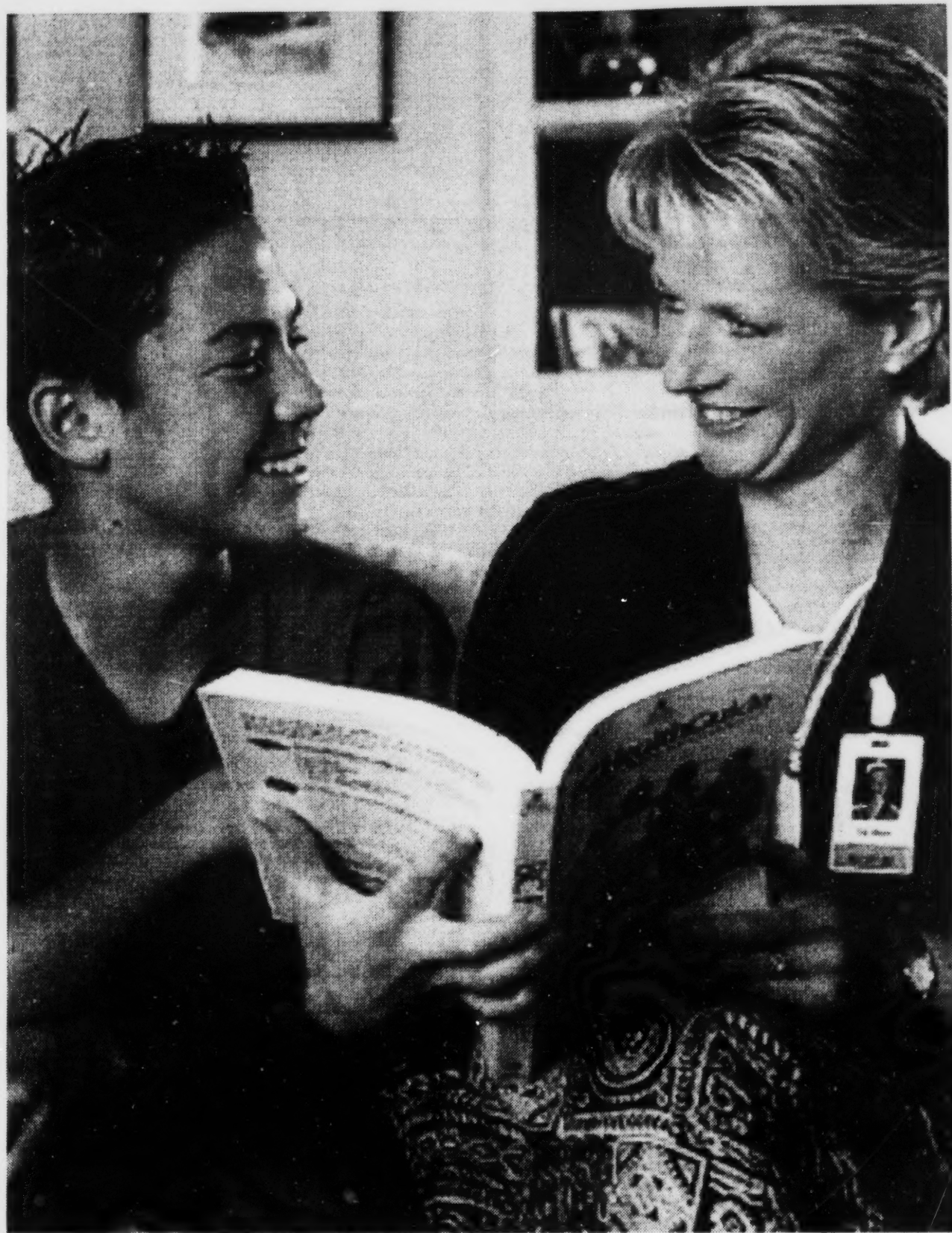
Health care is a top priority for the government and people of British Columbia. This annual performance report provides extensive information on the organization of the ministry, areas of performance and key events. It illustrates the state and performance of the provincial health care system. It also reports on accountability for dollars invested in B.C.'s publicly-funded health care system – \$8.8 billion in the 2000/2001 fiscal year.

The annual performance report of the Ministry of Health and Ministry Responsible for Seniors presents information on the performance of the ministry and our health care delivery system. This report takes a further step in providing information on the ministry's and province's success in achieving their mandate and goals, in accordance with the *Budget Transparency and Accountability Act*. In addition, the performance measures give a sense of the overall health of British Columbians and the accessibility, quality, affordability and sustainability of health care in the province.

This report includes four main sections. The structure of the ministry provides a brief description of its organization, programs and offices. The performance measures analysis section presents the results for the performance measures from the 2000/2001 Ministry of Health performance plan. The section on key areas of performance presents additional indicators and measures on overall health and services supported by the ministry. Finally, the section on key events highlights capital projects, programs and initiatives funded by the ministry during this fiscal year.

In this report, you will also find legislative amendments made in 2000, Acts and professions under the jurisdiction of the ministry, financial statements for the ministry, plus the organization of health authorities in British Columbia.

HEALTH CARE IS A
TOP PRIORITY FOR
THE GOVERNMENT AND
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PERFORMANCE REPORT
PRESENTS INFORMATION
ON THE PERFORMANCE
OF THE MINISTRY AND
OUR HEALTH CARE
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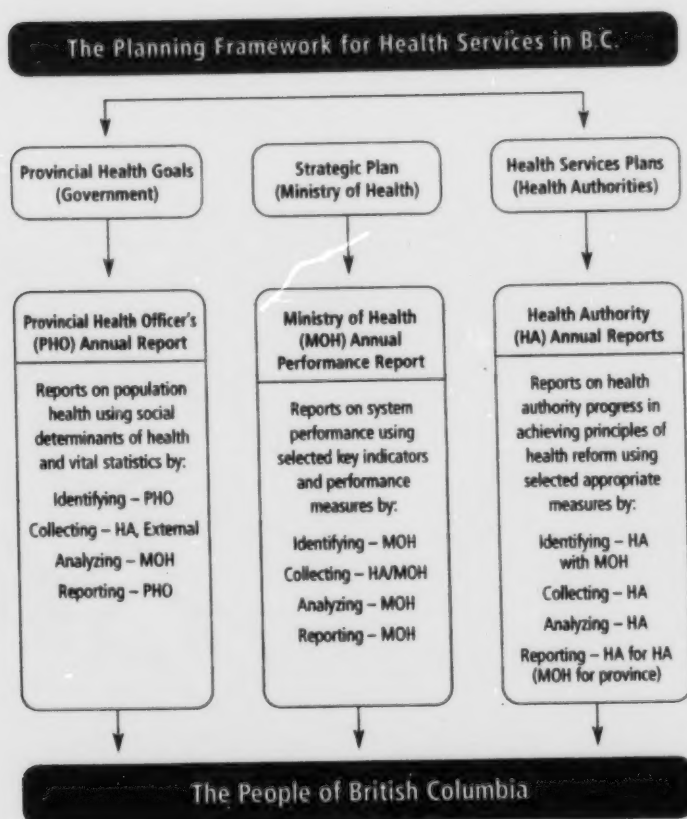




STRATEGIC PLANNING & REPORTING OF HEALTH SERVICES

The Ministry of Health has developed a 1999-2002 Strategic Directions plan, which provides a comprehensive planning and reporting framework for health services in B.C. As the following chart indicates, the ministry's

annual performance report is one of three types of documents that report on progress in achieving the province's health goals. The other two are the annual reports of the Provincial Health Officer and health authorities.





MINISTRY MISSION STATEMENT

The mission of the Ministry of Health is to support British Columbians in their efforts to maintain and improve their health. The ministry provides strategic direction and leadership of the health care system on behalf of the provincial government. Through a broad range of programs, services and public funding, the ministry is responsible for ensuring the maintenance of high quality, accessible, affordable health care for British Columbians.





STRUCTURE OF THE HEALTH CARE SYSTEM

In Canada, the federal government has established legislation, such as the *Canada Health Act* and the *Food and Drug Act*, to define the roles and responsibilities of governments in the regulation and delivery of health care services. The federal government provides health care funding support to the provinces. It regulates the safety of food, drugs, medical devices and other health products across the country. The federal government also has responsibility for aspects of surveillance and public health.

Like other provinces, British Columbia has responsibility for funding and services delivered by health care providers throughout the province. These services include wholly and partially funded health services, as well as services regulated but not funded by the government.

British Columbia has a progressive and integrated health care system. It is based on regional delivery and self-regulating professional colleges, providing quality, accessible and affordable health care. Although the Ministry of Health legislates and administers all aspects of our publicly-funded health care system, the health authorities are responsible for the delivery and management of health services in their communities. The health authorities include 11 Regional Health Boards, 34 Community Health Councils, and 7 Community Health Services Societies across the province.

The regional structure of B.C.'s health care system is outlined in maps, included in appendices to this report:

- Regional Health Boards (see Appendix 6, page 118)
- Community Health Councils (see Appendix 7, page 119)
- Community Health Services Societies (see Appendix 8, page 120)

BRITISH COLUMBIA
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HEALTH CARE





STRUCTURE OF THE MINISTRY

This section describes the structure of the Ministry of Health by areas of responsibility as of March 31, 2001. Organizational charts depicting the structure of the ministry at the beginning and end of the 2000/2001 fiscal year are included in Appendix I to this report.

REGIONAL PROGRAMS

Regional Programs consists of the following: Regional Operations; Regional Programs Policy and Strategic Initiatives; Funding, Planning and Evaluation; Tertiary Programs; Information Support; and, Provincial Priorities and Governance. The British Columbia Ambulance Service reports to the Associate Deputy Minister of Regional Programs, who serves as the Chair of the Emergency Health Services Commission. In 2000/2001, Regional Programs continued to strengthen the integration of services and to support health authorities in managing health service delivery, according to policies and guidelines established by the Ministry of Health.

Regional Operations

Regional Operations provides funding, policy direction and support to health authorities for the delivery of health services in institutional and community settings. The division's mandate is to support a coordinated delivery system for acute, specialized, tertiary, continuing and community care in order to provide British Columbians

with reasonable access to quality, sustainable health care services and to improve health status.

Regional Operations consists of regional teams, which serve as a link between the Ministry of Health and health authorities across the province. These teams support health authorities, ensure accountability for health services and evaluate progress toward improving British Columbians' health. The regional teams collaborate with health authorities, service providers, industry and other stakeholders in areas of policy, operating standards, accountability structures, monitoring systems and evaluation procedures for health services.

In 2000/2001, Regional Operations continued to work with other program areas within the ministry and with health authorities to evaluate performance of the health system, delivery of health services and population health. Health authorities submit health service plans for regional teams to review, approve and monitor for implementation. These plans are based on assessed priority health needs and demonstrate how health authorities propose to meet those needs with available resources. Health authorities are required to plan and deliver services, submit and maintain a balanced budget, and report on performance and progress in accordance with their approved plans.

THE DIVISION'S MANDATE IS TO SUPPORT A COORDINATED DELIVERY SYSTEM FOR ACUTE, SPECIALIZED, TERTIARY, CONTINUING AND COMMUNITY CARE IN ORDER TO PROVIDE BRITISH COLUMBIANS WITH REASONABLE ACCESS TO QUALITY, SUSTAINABLE HEALTH CARE SERVICES AND TO IMPROVE HEALTH STATUS



Regional Programs Policy and Strategic Initiatives

Regional Programs Policy and Strategic Initiatives provides leadership and policy development to ensure an environment free of significant health and safety hazards, a healthier society through the prevention and control of disease, and the well-being of people receiving care. It is responsible for the management and operation of the following: Clinical Support; Health Protection; Care Services; Regional Programs Policy and Strategic Initiatives; Prevention and Health Promotion; Aboriginal Health; Regional Programs Accountability; Tobacco Strategy; Office for Seniors; HIV/AIDS and Women's Health Bureau. It also oversees the management and operation of the British Columbia Centre for Disease Control Society.

The Clinical Support Branch ensures that policy and program initiatives are based on the best evidence available in scientific and research literature. The unit is also responsible for identifying the impact of strategic policy initiatives on the content, organization and evaluation of health services.

The Health Protection Division is responsible for policy development on public health protection. The division includes the Community Care Facilities, Public Health Protection and Radiation Protection branches.

The Community Care Facilities Branch is responsible for developing and implementing legislation, policy and guidelines to promote the health of people in licensed care facilities. Legislative authority is based on the *Community Care Facility Act*, the *Adult Care Regulations* and the *Child Care Licensing Regulation*. Programs are administered locally by Medical Health Officers and Licensing Officers who are responsible for service delivery in their respective areas of the province.

The Public Health Protection Branch provides advocacy and leadership in developing and managing strategies to minimize environmental health and safety risks to the public. It is responsible for the development and implementation of legislation, policies and standards to prevent disease from unsanitary practices and from exposure to environmental hazards. Legislation includes the *Health Act*, *Milk Industry Act*, *Fish Inspection Act* and the *Meat Inspection Act*, plus regulations pursuant to these Acts.

The Radiation Protection Branch provides expertise and leadership regarding health hazards and risks associated with radiation exposure. It is responsible for developing and implementing protection and prevention measures for the benefit of patients, workers and the public.

The Care Services Division provides management of and policy direction for the Adult Mental Health Policy and Mental Health Plan Implementation Branch, the Acute Care Services Policy Branch, and the Continuing Care Renewal Policy and Continuing Care Renewal Implementation Branch.

The Adult Mental Health Policy and Mental Health Plan Implementation Branch provides policy direction for the care of people with serious mental illness and supports the implementation of the Mental Health Plan – a strategic initiative of the ministry. The branch is responsible for sustaining and improving the delivery of accessible, effective and quality mental health services to British Columbians. It also aims to improve the mental health and well-being of British Columbians through strategies for protection, promotion and prevention. The branch continues to improve communication among mental health stakeholders and strategic planning for the broader mental health system with measurable outcomes.

The Acute Care Services Policy Branch develops provincial policy for acute care services for health authorities and contracted service providers. The branch ensures the policy remains consistent with the provincial and ministerial strategic direction, as well as with legislation.

The Continuing Care Renewal Policy and Continuing Care Renewal Implementation Branch is responsible for policy support, funding and monitoring the delivery of continuing care in B.C. The branch leads the implementation of British Columbia's *Strategic Directions for*

Continuing Care Renewal, which provides health authorities with the government's policy direction for the delivery of continuing care services. Continuing Care Renewal is intended to increase service capacity and redesign the existing continuing care system to improve access to an enhanced range of community support options for clients and caregivers.

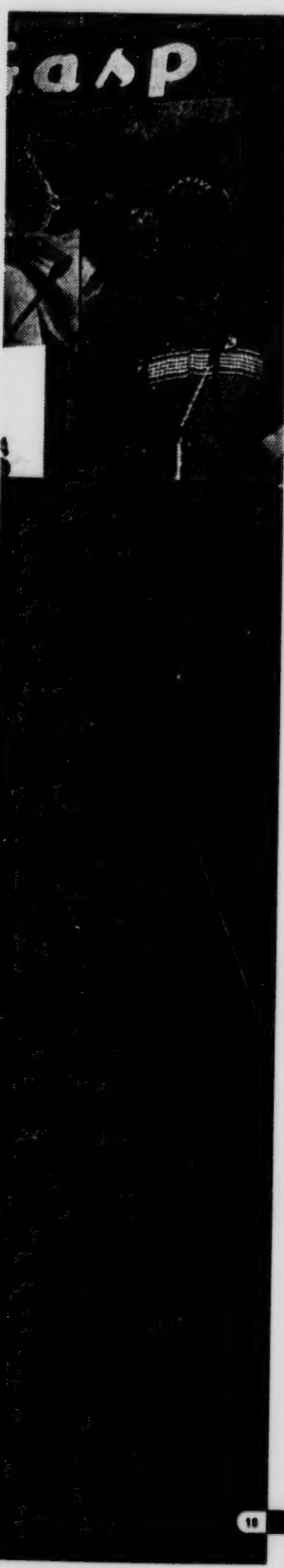
The Prevention and Health Promotion Division develops provincial standards, policies and priorities for public health and prevention. The division includes the following: Consumer Health Education Programs; Health and Disability Support Services; Population Health Surveillance and Epidemiology; Prevention and Health Promotion Strategies; and, Tobacco Reduction and Control Branch. These programs promote health and well-being, while reducing the risk and impact of illness, injury and disability. The division increases access to health information to assist British Columbians in making sound health-care decisions.

The Consumer Health Education Programs Branch oversees a range of provincial health education programs designed to improve access to health services, information and advice.

Health and Disability Support Services develops policies, standards and guidelines on support services for adults with disabilities to help them maintain optimal health and well-being.



THE CONTINUING CARE RENEWAL
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AND CAREGIVERS.



Population Health Surveillance and Epidemiology applies epidemiological methods for the surveillance and prevention of chronic disease, injuries and adverse environmental health effects. It is also responsible for promoting and evaluating public health programs.

Prevention and Health Promotion Strategies develops policies, standards, guidelines and monitoring systems for disease prevention and health promotion services for British Columbians. Policy areas include: communicable disease prevention and control; reduction of risk factors such as physical inactivity; primary prevention for chronic diseases such as cardiovascular disease and diabetes; and, health promotion related to nutrition and lifestyle.

The Tobacco Reduction and Control Branch is responsible for programs that prevent tobacco use among young people, support those who want to quit using tobacco, and protect British Columbians from the harmful effects of second-hand smoke.

The Aboriginal Health Branch has primary responsibility for providing advice, support and assistance on aboriginal health and policy direction. The branch is responsible for strengthening the ministry's relationships with aboriginal communities through negotiation, consultation and contract management. Its mission is to improve the health status of aboriginal people by improving access to health care, increasing control and decision making by aboriginal people, and building relationships with aboriginal communities, health partners, provincial ministries and federal departments.

The Regional Programs Accountability Branch provides leadership through strategic and business planning, policy development, regional accountability, information and analysis, and program support. It establishes an accountability framework for health authorities for the delivery of public health programs in B.C.

The Tobacco Strategy Branch provides leadership and strategic planning on tobacco issues impacting British Columbians. The main goals of B.C.'s tobacco strategy are to increase awareness of and protect youth from the harmful effects of tobacco, monitor and regulate the tobacco industry, and hold the industry accountable for damages caused. The ministry is active in providing British Columbians, especially youth, with the tools and information to protect themselves from the dangers of tobacco. Legislation, such as the *Tobacco Damages and Health Care Cost Recovery Act* and the *Tobacco Sales Act*, are key components of the provincial tobacco strategy.

The Office for Seniors is a focal point within the government for issues of concern to B.C. seniors. The office provides administrative support to the Minister Responsible for Seniors, as well as research support to the Seniors' Advisory Council. It monitors and collaborates on policy and program development across government. The office coordinates the activities of Senior Citizen Counsellors throughout the province. An important function of the Office for Seniors includes informing the public about benefits for seniors and promoting positive attitudes about aging and older people.

The HIV/AIDS Branch provides leadership and funding for a range of HIV/AIDS services in communities throughout the province. The branch administers grants to almost 50 HIV/AIDS organizations to provide community-based services. These include needle exchange services, harm reduction programs, street outreach programs, services for youth, women and ethnic minorities, plus food, housing, hospice and respite care for people living with HIV/AIDS and their caregivers. The branch leads the implementation of *British Columbia's Framework for Action on HIV/AIDS*, which outlines principles, objectives, roles, responsibilities and initiatives in addressing the HIV/AIDS epidemic. This includes inter-ministerial discussion and action on HIV/AIDS, as well as implementation of the *Framework* in coordination with *The Red Road: Pathways to Wholeness*, a *British Columbia Aboriginal AIDS Strategy* and the *Canadian Strategy on HIV/AIDS*.

The Women's Health Bureau assists the ministry in developing a health care system that is sensitive to the unique needs of women. Bureau staff work within government and liaise with community groups and health care providers to enhance understanding of women's health care issues. They also work with other ministries to address the broader social and economic needs of women. As well, the bureau acts as a secretariat to the Minister's Advisory Council on Women's Health.

The British Columbia Centre for Disease Control is funded by Regional Programs Policy and Strategic Initiatives, and operated by a society under governance of the Vancouver/Richmond Health Board. The centre coordinates the prevention and control of reportable communicable disease as specified by the *Health Act*, *Venerable Diseases Act* and *Communicable Disease Regulation*. It maintains registries and reports on communicable disease in the province. The centre also develops and recommends policy and procedures for the prevention, control surveillance and elimination of communicable disease. Furthermore, it provides diagnostic clinical services, referral laboratory testing, pharmaceutical services and distribution of vaccines in B.C. Specific program services include Sexually Transmitted Disease Control (STD/AIDS), Tuberculosis Control, Laboratory Services, Epidemiology Services and Pharmacy.

Funding, Planning and Evaluation

The Funding, Planning and Evaluation Division provides centralized fiscal planning and allocation direction to health authorities, cluster boards and allied agencies. It evaluates and monitors health resource utilization to ensure funding is used effectively to meet the health care needs of British Columbians. The division includes the Operational Support Branch and the Monitoring and Evaluation Branch.

The Operational Support Branch provides short-term and long-term planning and allocation of funds for the health sector.



THE WOMEN'S HEALTH BUREAU ASSISTS THE MINISTRY IN DEVELOPING A HEALTH CARE SYSTEM THAT IS SENSITIVE TO THE UNIQUE NEEDS OF WOMEN.



The Monitoring and Evaluation Branch evaluates and monitors the use of health care funding by health authorities, cluster boards and allied agencies. The branch ensures that funding is used appropriately to provide health services for British Columbians.

Program and Capital Planning

The Program and Capital Planning Branch is responsible for the development and coordination of a capital planning process for the Ministry of Health. This includes creating a capital planning framework, developing evaluation and ranking criteria, and evaluating capital project proposals. The branch also acts as the primary contact on capital planning for other government offices, health authorities and agencies.

Tertiary Programs

Tertiary Programs consists of the following branches: Tertiary Services and Vancouver Richmond Region.

Tertiary Services provides funding, policy direction and performance monitoring for tertiary services to ensure British Columbians receive highly specialized acute-care services in a timely and appropriate manner. This care can only be provided in designated facilities with staff having a high degree of expertise and experience. Tertiary facilities also need to have a sufficient volume of cases and procedures to provide competent and effective care.

The Vancouver Richmond Region Branch or team supports the Vancouver Richmond Health Board and other stakeholders in developing policy and establishing accountability mechanisms for the region.

Information Support

The Information Support Division uses both patient and organizational databases for analysing and reporting on the performance of health authorities to Regional Programs. The division also provides analyses and reports for program areas within the ministry, health authorities and other agencies. In order to provide reliable, timely and accurate information, Information Support provides advice on data quality and reporting requirements. It works closely with the ministry's Information Management Group on matters related to the reporting system, databases, tools and applications used to access and manipulate data.

The Organizational Reporting Branch

manages and produces information and reports on non-personal data from data sources, such as the Health Authority Management Information System.

The Analysis and Reporting Branch

manages issues related to reporting requirements. It establishes routine and special reports, and provides analytical and management information system support.

The Person-Based Records Branch manages and produces information and reports on client/patient data from data sources such as the Discharge Abstracts Database, the Client/Patient Information Management System, and the Continuing Care Information Management System.

Provincial Priorities and Governance

The Provincial Priorities and Governance Division is responsible for policy development, project management, and maintenance and expansion of initiatives that are priorities for the ministry and require collaboration with health authorities. This division oversees critical care, bedline, emergency room initiatives, patient transfers, midwifery, blood services and the surgical waitlist registry. It also provides governance policy for health authorities and strategic support to Regional Programs. This division consists of the Governance Branch and the Provincial Priorities Branch.

The Governance Branch provides policy direction on governance responsibilities and expectations of health authorities. It also manages the surgical waitlist strategy.

The Provincial Priorities Branch provides project management for existing and emerging programs to ensure a consistent and coordinated approach across the province.

The British Columbia Ambulance Service

The British Columbia Ambulance Service operates under authority of the *Health Emergency Act* and reports to the Emergency Health Services Commission. It provides air and ground ambulance services to British Columbians in 167 communities and surrounding areas. Approximately 3,300 employees respond to over 415,000 calls each year. Services are provided through 192 ambulance stations, three dispatch centres, an air ambulance dispatch centre and four regional administrative offices, in addition to the provincial headquarters in Victoria.

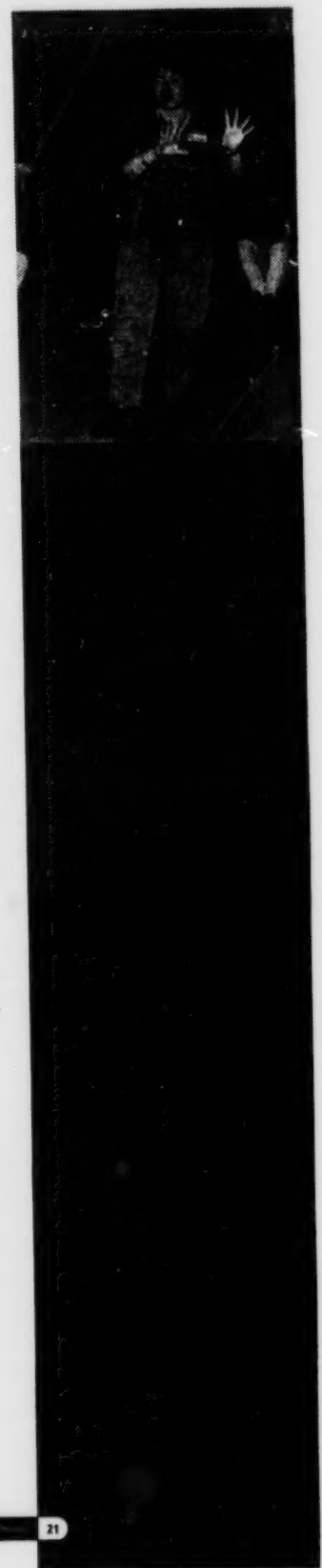
STRATEGIC PROGRAMS

Strategic Programs includes the following: Finance and Management Services Division; Strategic Policy and Research Branch; Strategic Planning and Reports Division; and, Intergovernmental Relations Branch.

The Finance and Management Services Division is responsible for the fiscal management and operation of the ministry. The division provides advice on financial administration and the financial implications of decisions at the planning and operational stages. It also ensures the implementation of legislative, regulatory and other financial requirements of the Legislature and central agencies. The division develops the ministry's annual budget submission to the Treasury Board and monitors actual expenditures throughout the year, ensuring compliance with the *Budget Transparency and Accountability Act*. It conducts reviews of the billing practices of physicians, pharmacists and supplementary benefit practitioners. It also responsible for processing and payment of all invoices for which goods and services have been delivered.

In addition, the division provides payroll services to 3,000 full-time staff and 2,200 part-time staff, including ambulance paramedics. Furthermore, it oversees building and office maintenance, including managing vehicles, phones and photocopiers.

The Strategic Policy and Research Branch is responsible for developing policy on a variety of strategic and corporate issues. It manages strategic projects on health care such as advanced nursing practice, patient satisfaction surveys and burden of disease analysis.



The branch also manages the ministry's health research portfolio and policy round series, intended to increase evidence-based decision making by providing current research to staff. Furthermore, it coordinates cross-program functions such as developing the ministry's Annual Regulatory Plan and responding to recommendations by the Children's Commissioner.

The Strategic Planning and Reports Division is responsible for planning and reporting processes for the ministry. The division develops, coordinates and reviews strategic plans in consultation with program areas, ministries and stakeholders. Specific areas of responsibility include health human resources planning, performance planning, strategic planning, annual reporting, health economics analysis, and evaluation of health services systems. A part of this division, the Nursing Directorate addresses a broad range of nursing issues at a provincial and national level, including nursing policy, program initiatives and human resources planning.

The Intergovernmental Relations Branch provides services to fulfill the ministry's mandate by coordinating activities within the ministry, between ministries and with other governments. Services include developing policy and providing support for federal, provincial and territorial meetings of ministers and deputy ministers of health. The branch provides project management, research analysis and advice on a broad range of intergovernmental issues. It is also responsible for the ministry's multicultural initiatives and annual multiculturalism report. A key service of the branch is events coordination for major meetings and conferences, including teleconferencing.

MEDICAL SERVICES PLAN/PHARMACARE

The Medical Services Plan is the mandatory medical insurance plan for residents of British Columbia. It provides payment for all medically required services by physicians and diagnostic facilities, according to the schedule of fees approved by the Medical Services Commission. The Medical Services Plan also administers registration of all B.C. residents as beneficiaries and provides payment for supplementary benefits.

The Medical Services Commission is established under the authority of the *Medicare Protection Act*.

The nine-member commission consists of three representatives each from the British Columbia Medical Association, the provincial government and the public.

The function of the commission is twofold: to facilitate reasonable access to quality medical, health and diagnostic services for residents of British Columbia; and, to develop more effective and affordable methods of managing the services under the Medical Services Plan.

The Strategic Planning and Program Development Division is responsible for informational and economic analysis, as well as program development, for the Medical Services Plan. It also provides policy direction, negotiations support and utilization management services. It leads program development on best practices and health outcome measures for physician services, including Clinical Practice Guidelines.

The primary function of the **Operations Division** is to administer the province's medical insurance plan by registering beneficiaries, billing premiums

and arranging payments for services. The division provides a premium assistance program for British Columbians with low incomes. It administers a Northern and Rural Locum Program to provide relief for northern and rural physicians to take leave from their practices. It also monitors health professionals' patterns of practice, investigates misuse of the medical insurance plan, and participates in practitioner fee negotiations.

As part of the Operations Division, the Supplementary Benefits Program provides coverage for the most comprehensive range of supplementary health care services in Canada, including chiropractic, dental surgery, massage therapy, naturopathy, optometry, physical therapy and podiatry. With the exception of dental surgery, the province provides funding for these services without cost sharing by the federal government.

The Pharmacare Program assists B.C. residents with the costs of prescription medication, permanent prosthetic appliances, designated children's orthotic devices, home oxygen and other medical supplies. The program administers benefits through eight different plans. The largest plans are those for seniors, income assistance recipients and the public. Pharmacare provides advice to government on federal regulation of prescription medication and the pricing of pharmaceuticals. It also works with professional colleges to encourage appropriate use of prescription medication.

CORPORATE PROGRAMS/ CHIEF INFORMATION OFFICER

Corporate Programs provides central operational support services to the ministry. Its primary

function is to provide program areas with expertise and leadership in human resources, information management and technology, information and privacy, legislation and professional regulation, and emergency preparedness. In addition, Corporate Programs represents the ministry in its dealings with central agencies of government, including the Public Employee Relations Commission and the Information, Science and Technology Agency.

The Legislation and Professional Regulation Branch is responsible for ensuring that the ministry's requirements for legislation are met. This includes the development of new legislation, the amendment of existing legislation, and the preparation of regulations and orders-in-council. The branch oversees the regulation of health professions and works with 22 professional colleges on governance issues. It also supports the work of the Health Professions Council and provides administrative support to the Mental Health Review Panels and four other appeal boards.

The Human Resources Branch provides advice and direction on all human resource matters within the ministry, including recruitment, selection and placement of staff, compensation and classification, staff development and training, human resource planning, employment equity, labour relations, organizational development, and occupational health and safety.

The Emergency Preparedness Branch is responsible for preparing the ministry to meet its obligations under the *Emergency Program Act*. Its mission includes working with health care providers to prepare the provincial health care system to



THE PHARMACARE
PROGRAM ASSISTS
B.C. RESIDENTS WITH THE
COSTS OF PRESCRIPTION
MEDICATION, PERMANENT
PROSTHETIC APPLIANCES,
DESIGNATED CHILDREN'S
ORTHOTIC DEVICES, HOME
OXYGEN AND OTHER
MEDICAL SUPPLIES. THE
PROGRAM ADMINISTERS
BENEFITS THROUGH EIGHT
DIFFERENT PLANS.



respond to and recover from any disaster that may threaten the health of British Columbians.

The **Information and Privacy Branch** supports the ministry's commitment to public accountability and protection of privacy in accordance with the *Freedom of Information and Protection of Privacy Act*. The branch provides advice and support on access and privacy issues to the ministry and health authorities. It also assists the public in accessing ministry records, while ensuring confidentiality of personal information.

The **Information Management Group** supports the goals of the ministry and B.C.'s health care system by providing province-wide information management strategies, policies, standards and technological initiatives. The division develops and implements a vision and strategic plan for information management, encourages compliance with policies and standards, and maintains the technological infrastructure for health applications. It coordinates information management and technology planning for the ministry. It also consults with program areas to provide services to fulfill business requirements. The division is responsible for the ministry's research library, records management, managed services contract (IBM) and Web services.

HealthNet/BC coordinates the development of the infrastructure for electronically linking the health sector. This division is responsible for setting standards and policy for health data and technology, including coordination with national standards organizations and federal/provincial/territorial jurisdictions. It manages all significant projects undertaken by

the **Information Management Group**. **HealthNet/BC** also coordinates consultation with health care partners, such as health authorities and professional colleges. It manages infrastructure and network services, facilitating access to the ministry's office and information systems.

The **Vital Statistics Agency** is responsible for the registration and certification of all vital events in the province under the authority of the *Vital Statistics Act*, *Marriage Act* and *Name Act*. The agency also maintains the **Wills Registry** and **Health Status Registry** under the sections of the *Wills Act* and *Health Act*. In addition, Vital Statistics publishes a wide range of data on vital events and health indicators in its annual report, quarterly digest and other publications. Established as a special operating agency in 1996, its activities and achievements are outlined in the annual *Financial and Performance Report*.

COMMUNICATIONS AND ISSUES MANAGEMENT

The **Communications and Issues Management Division** is responsible for the overall planning, implementation and evaluation of the ministry's communications activities. The division consists of the Executive Director's office, the **Corporate Communications Branch**, and the **Media Relations and Issues Management Branch**. Services provided by the division include issues management, communications project planning and management, media and public relations, advertising, and the development and execution of a wide range of health education and prevention initiatives.

LABOUR RELATIONS AND NEGOTIATIONS SUPPORT

The Ministry of Health established the Negotiations Support and Labour Relations Division in October 2000. Their mandate includes supporting labour negotiations in the health sector. These negotiations are the direct responsibility of the Health Employers Association of British Columbia. The central office also coordinates physician negotiations.

INNOVATION OFFICE

The Innovation Office was created in February 2001. Its mandate includes developing a framework for physician resource management and service contracts between the ministry, health authorities and physicians. The office is also responsible for developing models for innovative service arrangements for physician and other health services. The Innovation Office oversees three branches: Alternative Payments, Primary Care and Rural Health.

The Alternative Payments Branch is a component of the Innovation Office, operating under the authority of the *Medicare Protection Act*. The program develops innovative models for the funding, delivery and management of medical and related health services.

It is responsible for the development, implementation and monitoring of service and sessional agreements with health authorities and service providers throughout British Columbia.

The Primary Care Branch provides information and financial support to health authorities and health care providers to establish primary care centres in B.C. communities. This model of care provides patients

with an integrated continuum of health services 24-hours a day, 7 days a week from a multidisciplinary team of health professionals. The objectives of primary care renewal include enhancing coordination and delivery of services, and improving access to services in urban, rural and remote areas of the province.

The Rural Health Branch brings a ministerial focus to rural and remote health care issues in the province. Working in cooperation with other stakeholders and ministerial departments, the branch coordinates policies, legislation, programs and initiatives within the context of a regionalized health care system.

OFFICE OF THE PROVINCIAL HEALTH OFFICER

The Office of the Provincial Health Officer is legislated by the *Health Act* to report independently to the Minister of Health, the ministry and the public on health issues in British Columbia.

The functions of this office include advising on health issues, producing an annual report on the health of the population, reporting on progress toward the government's health goals, and assisting the ministry with issues management and program and policy development. The office also works with the British Columbia Centre for Disease Control and the Medical Health Officers to fulfill the legislated health protection and disease control mandate. The Provincial Health Officer chairs British Columbia's Communicable Disease Policy Committee and serves as a member of the Federal, Provincial and Territorial Advisory Committee on Population Health.



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PERFORMANCE MEASURES ANALYSIS

WHY MEASURE PERFORMANCE?

In this annual performance report, the Ministry of Health provides extensive information on the performance of B.C.'s publicly-funded health care system. Tracking and reporting this information is consistent with the ministry's increasingly strategic approach and its responsibilities for performance planning and reporting, under the *Budget Transparency and Accountability Act*. The ministry has a strong commitment to ensuring British Columbians get the greatest health benefit possible for every tax dollar devoted to health care. This report presents a wide range of performance measures for several reasons, including:

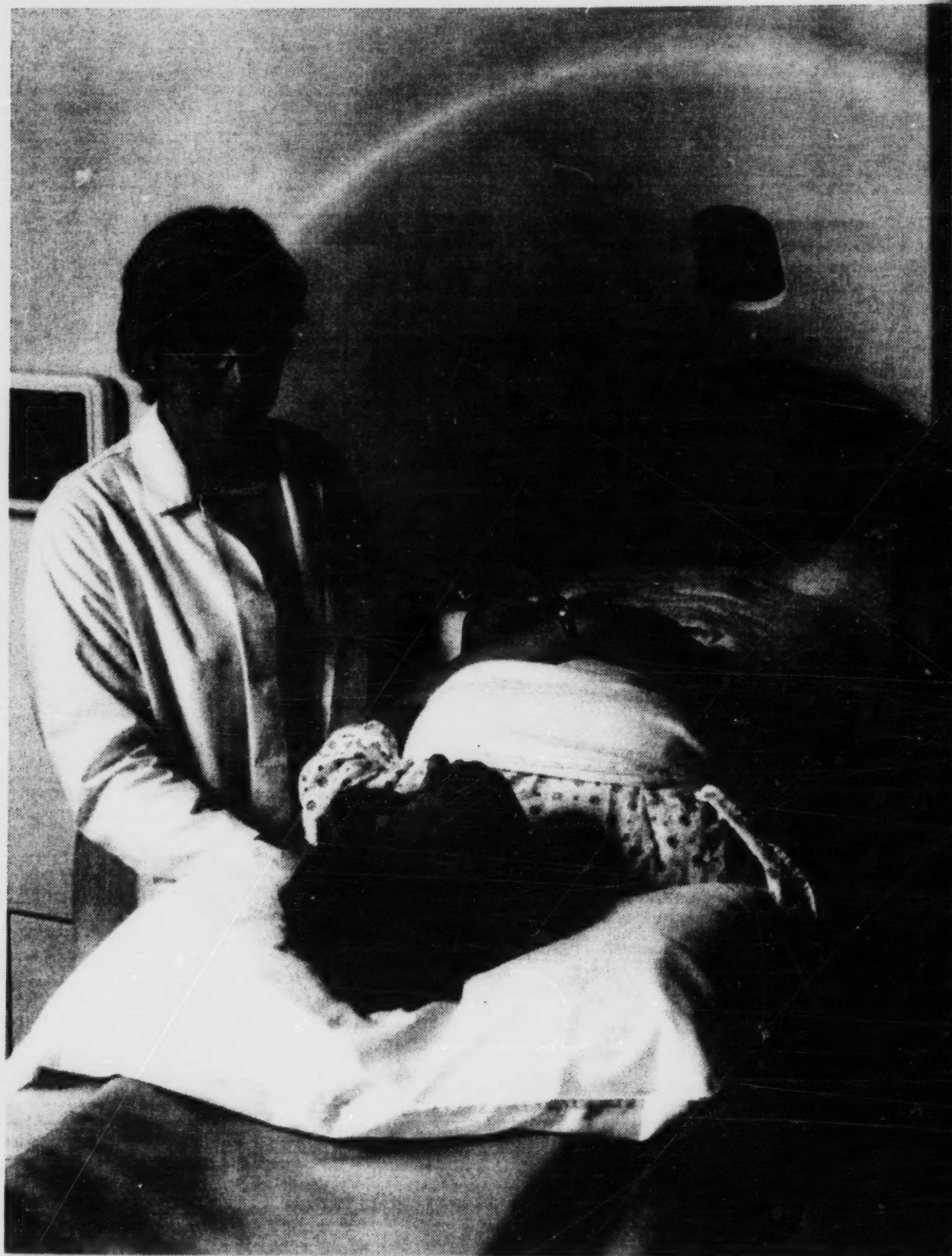
- People care – British Columbians want to ensure health services will be available for them and those they care about when they need them. Performance measurement is one way to keep track of the quality, accessibility and delivery of these services.
- It increases learning – By measuring performance across the province, it is possible to learn from the experience of those who are achieving greater success. Performance measurement helps us learn and share good ideas.

- It is essential to strategic planning and accountability – Strategic planning involves using available resources in ways that generate the best possible results for every dollar spent. Performance measurement helps to determine if specific initiatives are effective and to adjust them if there are better ways to achieve our province's health goals.

How Do We Measure Performance?

It isn't always easy to measure performance, mainly because there are multiple factors that contribute to health outcomes. The functioning of our health care system can be measured to the extent it achieves specific performance objectives. In this report, the ministry provides information on performance in two ways. In the following section, the ministry reports on the results or outcomes for the performance measures contained in its 2000/2001 performance plan. The second section – Key Areas of Performance – provides supplementary information on key indicators that report on the health of British Columbians and both the ministry's and the health system's performance in achieving health outcomes.

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PERFORMANCE PLAN MEASURES

In accordance with the *Budget Transparency and Accountability Act*, the Ministry of Health is reporting on the results or outcomes for the performance measures contained in its 2000/2001 performance plan. This section provides detailed information on the ministry's performance objectives, measures and outcomes for the 2000/2001 fiscal year.

REGIONAL PROGRAMS: REGIONAL OPERATIONS

KEY PROGRAM OBJECTIVE

Continue to develop accountability and monitoring mechanisms for health authorities in the areas of acute care, continuing care, mental health and public and preventive health.

PERFORMANCE MEASURE

- Ministry and health authority to determine performance measures jointly.
- Monitor and report on financial, service utilization and outcome data.

STATUS/OUTCOME

- The health authority performance indicators report was completed in draft form and sent to health authorities for their review in March 2001. It will be published by end of summer 2001.

KEY PROGRAM OBJECTIVE

Address the availability and timeliness of cancer care.

PERFORMANCE MEASURE

- Establish wait time standards and report actual wait times for surgical oncology.

STATUS/OUTCOME

- Standards are under development and targeted for completion in 2000/2001. A Surgical Oncology Committee was created. The ministry's Executive Director of Tertiary Programs is a member.

KEY PROGRAM OBJECTIVE

Implement an integrated three-year capital planning process for health authorities.

PERFORMANCE MEASURE

- Health authorities to submit 2001/2002 capital plans by June 2000. Plans must meet ministry requirements, including completion of a project study for major and minor Treasury Board projects.

STATUS/OUTCOME

- Health authorities advised that three-year capital plans are required for 2002/2003.
- Project studies are being completed as required. This is consistent with the April 2000 Deloitte Consulting report on the province's capital management process.

REGIONAL PROGRAMS: REGIONAL OPERATIONS CONTINUED

KEY PROGRAM OBJECTIVE

Review and assess opportunities for improvements to the Emergency Medical Coverage Program for Northern & Isolation Allowance Communities.

PERFORMANCE MEASURE

- Complete evaluation of the Emergency Medical Coverage Program and develop ministry recommendations.

STATUS/OUTCOME

- Evaluation report completed on the Emergency Medical Coverage Program. Future on-call and recruitment and retention benefits are the subject of negotiations with the British Columbia Medical Association.

KEY PROGRAM OBJECTIVE

Enhance the provincial wait list strategy.

PERFORMANCE MEASURE

- Expand the Surgical Wait List Registry to increase the number of hospitals reporting.

STATUS/OUTCOME

- Fourteen new hospitals began submitting data to the Surgical Wait List Registry on April 1, 2000, for a total of 48 hospitals participating in the registry.

KEY PROGRAM OBJECTIVE

Enhance tertiary services.

PERFORMANCE MEASURE

- Develop and implement a Provincial Trauma Strategy.
- Develop and implement Cardiac Costing Model.

STATUS/OUTCOME

- Provincial Trauma Strategy developed and committee established.
 - Six regional trauma centres established throughout B.C.
 - Two provincial trauma centres established at Vancouver General Hospital and B.C. Children's Hospital.
- Cardiac Costing Model was developed and implemented.

KEY PROGRAM OBJECTIVE

Monitor and promote appropriate utilization of the blood supply.

PERFORMANCE MEASURE

- Increase number of hospitals reporting to central transfusion registry.
- Complete transfusion surveillance pilot project.

STATUS/OUTCOME

- 100 per cent of hospitals report to the central transfusion registry.
- Transfusion surveillance pilot project completed.
- Developed framework for hospital-based reporting of transfusion reactions. Prepared strategy for implementation in six pilot hospitals.

REGIONAL PROGRAMS: PUBLIC & PREVENTIVE HEALTH

KEY PROGRAM OBJECTIVE

Reduce tobacco use and, in particular, protect young people from tobacco.

PERFORMANCE MEASURE	STATUS/OUTCOME
• Continue Contribution Agreement with federal government. • Distribute a retailer toolkit. • Distribute the Annual Report of the Teen Tobacco Team. • Distribute the Aboriginal Tobacco Reduction Strategy for consultation. • Distribute school-based prevention resources.	• 2000/2001 Contribution Agreement signed. Negotiations for the 2001/2002 Agreement are underway. • Retailer toolkit to be distributed in spring 2001. • 1999/2000 annual report for the Teen Tobacco Team distributed in September 2000. Next annual report to be released in September 2001. Recommendations are being reviewed. • Consultation completed and Aboriginal Tobacco Strategy released in January 2001. • School-based prevention resources like <i>bc.tobaccofacts</i> 4-5 distributed in September 2000, and <i>bc.tobaccofacts</i> 8-12 will be distributed in September 2001.

KEY PROGRAM OBJECTIVE

Reduce injury, cardiovascular disease and skin cancer in British Columbia.

PERFORMANCE MEASURE	STATUS/OUTCOME
• Complete review of emergency department injury surveillance systems and develop a best practices document to prevent sport/recreation injuries. • Develop Cardiovascular Disease Prevention Strategy. • Develop Sun Awareness/Skin Cancer Strategy, action plan and Sun Awareness Resource.	• Completed a review of emergency room injury surveillance systems and trial systems initiated in 11 hospitals. • Completed draft of best practices document on prevention of sports injuries, which will be released early fiscal 2002. An expert group is reviewing the draft to ensure quality and acceptance. • Developed a draft <i>Cardiovascular Disease Prevention Strategy: A Component of Chronic Disease Prevention for British Columbians</i> and conducted consultation with stakeholders. • Developed and published a Sun Awareness and Skin Cancer Prevention Strategy for B.C. Draft strategy action plan and education resources were developed.

REGIONAL PROGRAMS: PUBLIC & PREVENTIVE HEALTH CONTINUED

KEY PROGRAM OBJECTIVE

Reduce the spread of HIV/AIDS and improve the quality of life for people living with HIV/AIDS and their caregivers.

PERFORMANCE MEASURE

- Implement the HIV/AIDS Framework, the Red Road: Provincial Aboriginal HIV/AIDS Strategy and the regional planning process.
- Improve access and increase usage of community-based HIV/AIDS services and needle exchange programs.
- Develop standards and outcomes for HIV/AIDS services.
- Increase stakeholder involvement and collaboration.

STATUS/OUTCOME

- The ministry has committed resources to the Red Road Network for implementing the strategy.
- The ministry participates in the Inter-ministerial Committee on HIV/AIDS.
- Needle exchanges across B.C. reported an increase in the number of needles exchanged.
- A best practices review is underway for developing standards and outcomes for services.
- Meetings at needle exchanges were held to identify harm reduction policy issues. Ministry staff attended meetings with the Pacific AIDS Network.
- The ministry's 1999/2000 HIV/AIDS Advisory Committee report was published.

KEY PROGRAM OBJECTIVE

Protect the health of British Columbians through enhanced immunization reporting and surveillance of diseases, disease patterns and adverse health effects.

PERFORMANCE MEASURE

- Enhance a national and provincial communicable disease database.
- Participate in implementation of national/provincial diabetes surveillance system.

STATUS/OUTCOME

- New immunization programs were launched, including infant hepatitis B, pneumococcal immunization for high risk people ages 2-65, and expanded Hepatitis A immunization.
- B.C. leads the country with a Public Health Information System (PHIS) for tracking communicable diseases.
- Initial phase for Web enablement of PHIS, which includes Outbreak STD and TB modules.
- Participated in the first year of a four-year implementation project for the national/provincial diabetes surveillance system.

REGIONAL PROGRAMS: PUBLIC & PREVENTIVE HEALTH CONTINUED

KEY PROGRAM OBJECTIVE

Improve the health status of Aboriginal people in British Columbia.

PERFORMANCE MEASURE

- Develop and implement a Provincial Aboriginal Health Services Strategy (PAHSS).
- Improve relationship between Aboriginal communities, regional Aboriginal health councils and health authorities through implementation of the Aboriginal Governors Working Group (AGWG) recommendations.
- Devolve Aboriginal Health Division funding consistent with the goals of PAHSS and with the principles of regionalization.
- Develop options for formalizing Aboriginal involvement in the health planning process.
- Improve accountability to Aboriginal communities for program and services funding.

STATUS/OUTCOME

- The Provincial Aboriginal Health Services Strategy (PAHSS) activities have included information sessions with Aboriginal communities and the development of a pilot Provincial Health Services document. Work continues toward a health needs assessment and recommendations.
- Formal consultations are underway with Aboriginal communities to develop the provincial strategy.
- An Aboriginal governors committee will advise the Ministry of Health on implementing the working group's recommendations.
- The ministry has acted on a number of recommendations, notably the requirement for Aboriginal health plans and an increase in the number of Aboriginal governors.
- The ministry is developing specific requirements for Aboriginal health service plans to be implemented in December 2001.
- The ministry continues to work with the Aboriginal health stakeholders to develop clear mandates, funding mechanisms, collaborative processes and accountabilities. Recommendations will be presented for ministry approval for potential action in the 2002/2003 fiscal year.
- Work continues with Aboriginal communities and health authorities to identify collaborative processes.
- Improved accountability is being addressed for relationship development, governance and health services planning.

REGIONAL PROGRAMS: ADULT MENTAL HEALTH

KEY PROGRAM OBJECTIVE

Support health authorities' capacity to strengthen mental health services, including those serving rural and remote communities.

PERFORMANCE MEASURE

- Develop best practices resources and tools.
- Provide policy direction on suicide prevention.
- Develop guidelines and standards for elderly mental health care.
- Establish acute diversion programs.
- Develop TeleMental Health guidelines and explore alternative sources of funding.
- Support rural and remote regional health authorities in planning, capacity building, determining best practices and policy interpretation.
- Develop standards for hospital-based psychiatric emergency services and observation units.

STATUS/OUTCOME

- Developed and distributed best practices resources and tools, reflected in *Best Practices for BC's Mental Health Reform*, focusing on housing, assertive community treatment, crisis response/emergency services, inpatient/outpatient services, consumer involvement and initiatives, family support and involvement, and psychosocial rehabilitation.
- Developed policies and guidelines on suicide prevention, including clinical practice parameters, data collection and information dissemination, supported through regional presentations.
- Developing guidelines and standards for elderly mental health care planning for health authorities, which will be completed in 2001/2002.
- Supported health authorities in the establishment of Acute Diversion Programs in three communities.
- Developed TeleMental Health guidelines for the development and implementation of TeleMental Health in the Peace Liard region.
- Provided mental health consultation services to the Peace Liard, Northwest and Cariboo regions.
- Developed and disseminated standards for hospital-based psychiatric emergency services.
- Supported development of 11 observation units and staff training required to operationalize.

REGIONAL PROGRAMS: ADULT MENTAL HEALTH CONTINUED

KEY PROGRAM OBJECTIVE

Develop mechanisms for accountability in mental health services.

PERFORMANCE MEASURE

- Outline policy direction and expectations for the implementation of mental health reform for health authorities.
- Develop performance monitoring framework and baseline report.
- Develop framework for quantitative measurement of outcomes.
- Develop standardized provincial consumer and family satisfaction indicators.
- Develop a framework of practice and core competencies for the mental health workforce.

STATUS/OUTCOME

- Developed and distributed document, *Foundations for Reform - Policy Framework and Key Planning Tools*, followed by presentations throughout the province.
- Developed and distributed provincial report, *Assessing the Performance of the British Columbia Mental Health System*, and made presentations to health authorities.
- Supported development of a framework for quantitative measurement of outcomes in partnership with the Mental Health Evaluation and Community Consultation Unit (MHECCU), the University of British Columbia (UBC).
- Supported development of a standardized provincial consumer and family indicators survey measuring consumer and family satisfaction, which was administered province-wide.
- Developed a framework of practice and core competencies for the mental health workforce, currently being validated through focus groups.

KEY PROGRAM OBJECTIVE

Support initiatives that strengthen the inclusion and contributions of mental health consumers and their families in service planning and evaluation.

PERFORMANCE MEASURE

- Provide support to the Minister's Advisory Council on Mental Health.
- Develop framework for a provincial Mental Health Charter of Rights.
- Develop policies and guidelines to support families with parental mental illness.
- Develop policies and guidelines on mental health peer support.

STATUS/OUTCOME

- Provided secretariat and planning support for the Minister's Advisory Council on Mental Health and for quarterly meetings in different venues across the province.
- Development of a framework for a provincial Mental Health Charter of Rights is underway.
- Developed a draft document, *Support to Families with Parental Mental Illness*, to be distributed in 2001/2002.
- Drafted *Peer Support Manual* to be distributed in 2001/2002.

REGIONAL PROGRAMS: ADULT MENTAL HEALTH CONTINUED

KEY PROGRAM OBJECTIVE

Develop strategies with related partners to better serve special needs populations.

PERFORMANCE MEASURE

- Support the Assistant/Associate Deputy Ministers (ADMs) Committee on Mentally Disordered Offenders.
- Continue to support the Early Psychosis Initiative.
- Develop depression strategy.
- Develop best practices information on mental illness and developmental disabilities.
- Develop best practices information for Aboriginals, seniors and women.
- Develop anxiety disorders framework.
- Support the Fetal Alcohol Syndrome Inter-ministry Working Group.

STATUS/OUTCOME

- Supported the ADMs Committee on Mentally Disordered Offenders to broaden its scope to encompass the needs of all individuals with mental disorders with complex needs, which often cross jurisdictional responsibilities.
- Strengthen the Early Psychosis Initiative through skills development for regional and inter-ministry program staff (Ministry for Children and Families, Ministry of Education) and health authorities that identify and treat individuals (aged 17 to 28) with early psychosis.
- Initiated work on the development of a depression strategy focusing on prevention, early detection, treatment and public education, plus the development of policies and guidelines.
- Initiated a Best Practices Working Group on mental illness and developmental disabilities.
- Drafted a best practices resource for Aboriginals, seniors and women to be distributed in 2001/2002.
- Drafted a discussion paper on Aboriginal mental health best practices in partnership with the Aboriginal Health Branch.
- Initiated work on the development of an anxiety disorders framework and strategy, including policies, clinical standards and guidelines, for adoption by health authorities.
- Continued participation in the provincial Fetal Alcohol Syndrome/Fetal Alcohol Effect Working Group and supported the Ministry for Children and Families as the lead ministry.

REGIONAL PROGRAMS: ADULT MENTAL HEALTH CONTINUED

KEY PROGRAM OBJECTIVE

Develop strategies with related partners to better serve special needs populations. (Continued)

PERFORMANCE MEASURE

- Expand the number of subsidized housing units made available to special needs populations.
- Develop concurrent disorder demonstration project.
- Develop assessment and treatment guidelines for women with mental illness.
- Develop framework to increase access to competitive employment for the target population.

STATUS/OUTCOME

- Worked with the BC Housing Management Commission (BCHMC) to increase the number of subsidized housing units available to special needs populations through BCHMC owned and non-profit housing societies.
- Supported initiation of concurrent disorder demonstration project to support consumers with mental health and substance abuse in an integrated fashion.
- Developed draft assessment and treatment guidelines for women with mental illness during pregnancy and post-partum, to be distributed in 2001/2002.
- Supported four women's mental health demonstration projects. Reports to be distributed in 2001/2002.
- Supported three-year initiative to increase access to competitive employment for the target population, based on best practices Psychosocial Rehabilitation and Recovery Models.

REGIONAL PROGRAMS: B.C. AMBULANCE SERVICE

KEY PROGRAM OBJECTIVE

Maximize resource utilization and enhance service availability.

PERFORMANCE MEASURE

- Evaluate appropriate utilization of ambulance resources and improve response times.

STATUS/OUTCOME

- Overall, response times increased slightly due to increased volumes and other factors that the B.C. Ambulance Services continues to analyze.

KEY PROGRAM OBJECTIVE

Enhance quality of patient care by expanding local access to Paramedic Training Programs.

PERFORMANCE MEASURE

- Install computers in as many stations as funding allows.

STATUS/OUTCOME

- Computers were installed in every station, vastly improving access to Canadian Medical Association training.

REGIONAL PROGRAMS: CONTINUING CARE PLAN

KEY PROGRAM OBJECTIVE

Develop a comprehensive renewal strategy for continuing care services.

PERFORMANCE MEASURE

- Complete a staged and costed implementation plan for renewing continuing care services.

STATUS/OUTCOME

- Developed and distributed *Strategic Directions for Continuing Care Renewal*, outlining government's policy direction to health authorities.
- Began implementing a five-year plan for continuing care renewal. Provided funding to health authorities to adopt or develop new service models to meet the needs of B.C. residents and communities.
- The government approved funding to open 2,000 new residential care beds by 2005.
- Introduced a new Palliative Care Benefits Program, which supports and enables individuals in the end-stage of a life-threatening illness or disease to remain at home. This program covers costs of medications, medical supplies and equipment.
- Established the Continuing Care Implementation Committee to provide leadership for the implementation of continuing care renewal.
- Provided health authorities with *Requirements for Continuing Care Renewal Plans 2000/2001 - 2004/2005*. Health authorities are required to develop a five-year plan for achieving service goals.
- Initiated a Steering Committee to oversee implementation of a new application, assessment and classification system.
- Initiated a pilot project to evaluate selected assessment tools and to determine required modifications for use in B.C.

MEDICAL SERVICES PLAN/PHARMACARE

KEY PROGRAM OBJECTIVE

Provide a continuum of medical services to meet the diverse needs of B.C. patients.

PERFORMANCE MEASURE

- Implement the Selfcare/Telecare project.
- Publish the Primary Care Demonstration project final report.

STATUS/OUTCOME

- Implemented the B.C. HealthGuide Program to provide accurate, comprehensive health information and advice to B.C. residents. The B.C. HealthGuide Handbook was distributed to every B.C. household. This program also provides 24/7 access to B.C. HealthGuide OnLine and B.C. HealthGuide NurseLine.
- The Primary Care Demonstration project final report was completed and submitted to the federal government. This report is being distributed both provincially and nationally.
- The ministry developed and implemented a primary care delivery model.
- Federal requirements under the Health Transition Fund project are completed.

KEY PROGRAM OBJECTIVE

Improve access to necessary medical care for all British Columbians.

PERFORMANCE MEASURE

- Implement a rural action plan.
- Develop a physician resource plan.
- Increase number of Alternative Payment service agreements by at least 15 per cent.

STATUS/OUTCOME

- Implementation of several rural recruitment and retention initiatives for physicians such as the Physician Recruitment and Retention Program, Rural Subsidy Agreement, Medical Education Action Plan and Clinical Videoconferencing Pilot Project.
- Creation of Rural Nurse and Health Practitioner recruitment and retention initiatives.
- A Physician Resource Planning Committee was established, under authority of the Medical Services Commission. This committee's mandate is to review current distribution of physician resources in B.C., to develop a provincial strategy to facilitate reasonable access to needed medical services, and to establish one-year and five-year physician resource plans.
- An increase from 86 to 102 service agreements achieved, translating to an 18.6 per cent increase.

MEDICAL SERVICES PLAN/PHARMACARE CONTINUED

KEY PROGRAM OBJECTIVE

Work towards continuous improvement in medical care.

PERFORMANCE MEASURE

- Increase number of protocols and guidelines.
- Increase opportunities for multi-disciplinary delivery of primary care.

STATUS/OUTCOME

- Developed four new clinical practice guidelines and revised five others, now adopted by the Medical Services Commission.
- New primary health centres announced for Agassiz, Ashcroft, Clinton, Francois Lake, Kaslo, Logan Lake and Vancouver.

KEY PROGRAM OBJECTIVE

Manage and deliver medical services effectively.

PERFORMANCE MEASURE

- Complete agreements with physicians and other health care practitioners, providing cost certainty and effective management mechanisms.
- Implement utilization measures that contain physician billings within established budgets.

STATUS/OUTCOME

- Second Master Agreement concluded February 2001. Negotiations with physicians are underway to renew working and existing Subsidiary Agreements. Additional negotiations are underway to develop two new Subsidiary Agreements for General Practitioners and Specialists to address fee-for-service issues.
- The Medical Services Commission has approved the work plan, including 18 utilization initiatives, for the British Columbia Medical Association/Medical Services Plan Joint Utilization Committee.

KEY PROGRAM OBJECTIVE

Manage growth of expenditures while maintaining appropriate access and quality of care.

PERFORMANCE MEASURE

- Manage expenditures within the budget.

STATUS/OUTCOME

- Program expenditures and administration managed within budget.

KEY PROGRAM OBJECTIVE

Improve utilization initiatives.

PERFORMANCE MEASURE

- Increase volume of drug utilization studies.

STATUS/OUTCOME

- Health Transition Fund Projects underway include:
 - The Canada Drug Guide;
 - Options for Prescription Drug Utilization Study (OPUS);
 - Reference Drug Program and Special Authority Cost/Benefit Analysis.

MEDICAL SERVICES PLAN/PHARMACARE CONTINUED

KEY PROGRAM OBJECTIVE

Complete follow-up to Auditor General's Report.

PERFORMANCE MEASURE

- All recommendations addressed.

STATUS/OUTCOME

- The majority of the recommendations have been fully or substantially implemented:
 - 7 fully implemented;
 - 4 substantially implemented;
 - 1 partially implemented.

KEY PROGRAM OBJECTIVE

Improve administrative and operational service.

PERFORMANCE MEASURE

- Increase stakeholder satisfaction levels.

STATUS/OUTCOME

- PharmaNet services are available 99.9 per cent of the time.
- PharmaNet Helpdesk:
 - 96 per cent of calls answered under 46 seconds;
 - 3 per cent of calls answered within 46-90 seconds;
 - Special Authority Processing Times/Consistency and Comprehensibility of Special Authority communications;
 - Urgent, priority and regular requests all completed within target times.

KEY PROGRAM OBJECTIVE

Increase communication.

PERFORMANCE MEASURE

- Increase frequency of communication with pharmacists, physicians, drug manufacturers and interested public.
- Increase stakeholder satisfaction levels.

STATUS/OUTCOME

- Open dialogue maintained with pharmacists, physicians and other stakeholders:
 - Consultations with associations in process;
 - Survey/questionnaire developed;
 - Approximately 500 pieces of correspondence received.

STRATEGIC PROGRAMS

KEY PROGRAM OBJECTIVE

Develop strategic plans, business plans, accountability framework and related performance measures.

PERFORMANCE MEASURE

- Complete planning cycle.
- Develop ministry performance measures.

STATUS/OUTCOME

- The planning cycle was completed. The following planning and accountability activities were undertaken:
 - Ministry of Health Strategic Plan reviewed;
 - 2000/2001 Ministry of Health Performance Plan completed;
 - 2001/2002–03-04 Performance Plan prepared for release in April 2001;
 - Environmental Scan completed;
 - Planning and performance measurement activities integrated with budget process.
- Twenty-nine performance measures and corresponding targets were identified in the 2001/2002–03-04 Performance Plan.

KEY PROGRAM OBJECTIVE

Implement an integrated and collaborative planning approach for health human resources.

PERFORMANCE MEASURE

- Complete an analysis paper for each priority sector.
- Complete a coordinated Nursing Strategy to address current and anticipated shortages. The strategy will address training more nurses, hiring new nurses and retaining existing nurses.

STATUS/OUTCOME

- The Health Human Resources Advisory Committee (HHRAC) completed the analysis papers for the following four priority sectors: Laboratory Services, Medical Imaging, Pharmacy Services and Rehabilitation. Papers are still outstanding for the Home Support Services and IT Services sectors.
- Implementation of the second year of the Nursing Strategy is in progress.
- In the first year of the two-year Nursing Strategy:
 - 127 projects in 52 health authorities were funded for a total of over \$6.6 million for training, recruiting and retaining nurses;
 - \$500,000 were provided for nursing bursaries;
 - \$1,000,000 for health care scholarships.
- Review and revision of the Nursing Strategy will address changing and ongoing priorities for 2002/2003.

STRATEGIC PROGRAMS CONTINUED

KEY PROGRAM OBJECTIVE

Ensure that health authority policies and programs are responsive to women's health needs through support for gender-inclusive regional planning.

PERFORMANCE MEASURE

- Health Authority Service Plans to include women's health planning with 25 per cent of Health Authorities complying in 2000/2001.

STATUS/OUTCOME

- Approximately 25 per cent of the health service plans made mention of planning for women's health care related issues. It is expected that this percentage will increase for 2001/2002.

KEY PROGRAM OBJECTIVE

Negotiate and finalize agreements under the BC/Yukon Accord.

PERFORMANCE MEASURE

- Reciprocal agreement in place.
- Improve access to necessary health services for Northern B.C. residents.

STATUS/OUTCOME

- A reciprocal agreement is in place under the BC/Yukon Accord. Negotiations continue to establish additional agreements.
- Improved access to essential health services for Northern B.C. residents.

CORPORATE PROGRAMS/CHIEF INFORMATION OFFICER: CORPORATE PROGRAMS

KEY PROGRAM OBJECTIVE

Determine labour settlement costing information requirements.

PERFORMANCE MEASURE

- Make changes to the Health Sector Compensation Information System (HSCIS) to improve compliance with reporting requirements.

STATUS/OUTCOME

- This phase focused on the largest Health Sector employers (accounting for approximately 45,000 of the 77,000 FTE's tracked) and achieved over 80 per cent compliance (compared to approximately 45 per cent with the 'old' compensation system). In addition to increasing the compliance rate, other objectives of the project were to: automate the data collection process to reduce the amount of work required of the Health Sector employers in submitting data; improving error detection and correction, resulting in better data; and improving security when transmitting data from the employers to the system. Employers not included in the current phase who were not submitting data to the 'old' HSCIS began doing so, bringing combined compliance for the old and new systems up to 90 per cent.

CORPORATE PROGRAMS/CHIEF INFORMATION OFFICER: CORPORATE PROGRAMS CONTINUED

KEY PROGRAM OBJECTIVE

Perform internal audits to increase accountability in utilization of the health system.

PERFORMANCE MEASURE

- Reduce utilization statistics by patients, practitioners and medical laboratories. Audits of general practitioners, specialists, health care practitioners and pharmacists help to reduce health care costs by providing a deterrent against inappropriate billings. The following audits were carried out in 2000/2001.

STATUS/OUTCOME

	Medical Services Plan (MSP)	PHARMACARE	TOTAL
Onsite audits	27	12	39
Desk audits		53	53
Other projects (audit hearings and settlement negotiations)	61		61
Totals	88	65	153
Recoveries	\$1,102,840	\$468,643	\$1,571,483

KEY PROGRAM OBJECTIVE

Evaluate private collection agencies regarding the collection of outstanding MSP Premiums.

PERFORMANCE MEASURE

- Compare the Collection and Loan Management Branch (Ministry of Finance) collections and costs to those of private collection agents.

STATUS/OUTCOME

- Evaluation performed. Collection activities being transferred to the Collection and Loan Management Branch, as approved by Treasury Board.

KEY PROGRAM OBJECTIVE

Provide consultation and support to Ministry of Health on privacy and security issues.

PERFORMANCE MEASURE

- Prepare privacy impact statements for all new information systems.

STATUS/OUTCOME

- 8 privacy impact assessments completed.
- 3 privacy impact assessments in progress.
- Process initiated to ensure that new projects address whether privacy impact assessments are required.

KEY PROGRAM OBJECTIVE

Implement the required amendments to legislation governing the health professions.

PERFORMANCE MEASURE

- Delivery of consultation document in response to the Health Professions Council Legislative Review and completion of Request for Legislation.

STATUS/OUTCOME

- Health Professions Council delivered final report in March 2001. Ministry analysis and consultation processes began upon receipt of the report. Preparatory work is underway on a Request for Legislation.

**CORPORATE PROGRAMS/CHIEF INFORMATION OFFICER:
CORPORATE PROGRAMS CONTINUED**

KEY PROGRAM OBJECTIVE

Establish career development and succession planning initiatives.

PERFORMANCE MEASURE

- Develop self-assessment tools and deliver career planning education sessions.
- Increase representation of youth within the ministry.

STATUS/OUTCOME

- An on-line self-assessment tool was developed with a pilot project which concluded April 15, 2001. This tool is scheduled for ministry-wide release; education sessions will be scheduled following an Executive information session held on May 2, 2001.
- A Youth Recruitment Strategy has been implemented, including expanded education and information on employment opportunities. The ministry has experienced an overall increase in youth representation of 25 per cent in the last fiscal year.

KEY PROGRAM OBJECTIVE

Ensure ministry emergency preparedness by developing, communicating and exercising ministry response, business continuity and recovery plans.

PERFORMANCE MEASURE

- Publish an emergency preparedness plan for key ministry and other agency staff. Conduct orientation and drills.

STATUS/OUTCOME

- The Ministry is working with Health Authorities to develop a template for comprehensive, integrated all-hazards disaster plans for regional and local health services.
- Emergency operation centres in the ministry and B.C. Ambulance Service established and resourced to provide a facility for central coordination in a disaster.
- Business continuation plans for mission critical and priority business programs developed and exercised.

CORPORATE PROGRAMS/CHIEF INFORMATION OFFICER: INFORMATION MANAGEMENT GROUP

KEY PROGRAM OBJECTIVE

Provide access to information systems so that health outcomes will improve.

PERFORMANCE MEASURE

- Establish Hospital Emergency Room access to PharmaNet.
- Conduct pilot projects for implementation of PharmaNet in selected physicians' offices.
- Increase data availability for evidence-based decision making for health care sector, through HNDData.

STATUS/OUTCOME

- Thirty hospital emergency departments are currently connected to the PharmaNet system. The Ministry continues to encourage other hospitals to take advantage of this provincial information system.
- Eighty-five physician offices participated in a pilot program to connect to the PharmaNet system. The project is currently being evaluated. Early indications are that it was successful and will be helpful to physicians requiring information on their patient's drug profiles.
- A project to build a comprehensive database of anonymized data is in process. Phase 1, the inclusion of Medical Services Plan and PharmaNet data, is due for completion in the fall of 2001. Phase 2 will begin at the completion of Phase 1 and will include Continuing Care, Mental Health, Acute Care, Public Health, Contracted Medical Services and Primary Care data.

KEY PROGRAM OBJECTIVE

Develop and support an information infrastructure to meet the needs of the health care system and improve efficiency.

PERFORMANCE MEASURE

- Improve external access to ministry systems provided through HealthNet Interface (HNI).
- Develop more effective compensation information through the Health Sector Compensation Information System (HSCIS).

STATUS/OUTCOME

- A Web-based interface was put into production in 1999 allowing employers to register employees for the Medical Services Plan and check on eligibility, increasing efficiency for employers and the ministry. During the last year, 412 clients have begun using the HealthNet Interface.
- The Health Sector Compensation Information System (HSCIS) was re-engineered and now collects compensation information on the majority of the employees in the health system. The data is used for health human resource planning and management.

CORPORATE PROGRAMS/CHIEF INFORMATION OFFICER: INFORMATION MANAGEMENT GROUP CONTINUED

KEY PROGRAM OBJECTIVE

Develop and support an information infrastructure to meet the needs of the health care system and improve efficiency.

PERFORMANCE MEASURE

- Establish business and technical standards for the electronic exchange of lab test data, establish common standards for electronic health claims, and create a centralized, province-wide registry for provider and facility data.

STATUS/OUTCOME

- A Lab Test Standard has been developed and adopted in B.C. and other western provinces. The E-Claims Standard, which began in B.C., is under development and has been adopted as a National Level Project with participation by other provinces and the Canadian Institute for Health Information (CIHI).
- This project has been approved for joint funding by the four western provinces and has received a grant from Health Canada, under the Canadian Health Information Partnership Program. The E-Claims Standard will be done in two phases with physicians and nurses in Phase 1 and other providers in Phase 2. The development of a Provider Registry enables the creation of an electronic health record.

KEY PROGRAM OBJECTIVE

Provide access to health services information for Health Authorities and the Ministry of Health to improve research and program planning.

PERFORMANCE MEASURE

- Improve external access to ministry systems provided through HealthNet Interface.
- Facilitate evidence-based research, planning and decision making for the health care sector by implementing HealthNet Data (Health Data Warehouse).

STATUS/OUTCOME

- This Web-based HealthNet Interface was put into production in 1999. It will allow employees to register for the Medical Services Plan and check on eligibility, saving time for employers and the ministry. During the last year, 412 clients began using the HealthNet Interface. There were a total of 237,966 transactions.
- The project to build a comprehensive database of anonymized data is on time and on budget. Phase 1 – the inclusion of MSP and PharmaNet data – is due for completion in the fall of 2001. Phase 2 will begin at the completion of Phase 1 and will include Continuing Care, Mental Health, Acute Care, Public Health, Contracted Medical Services and Primary Care data.

KEY PROGRAM OBJECTIVE

Provide the necessary tools to support the infrastructure.

PERFORMANCE MEASURE

- Enhance security through HealthNet Secure.
- Keep security controls and access current.

STATUS/OUTCOME

- The security product enables the transfer of confidential information over the Internet. The product and other security controls and access are continually updated to ensure they meet current technology and privacy requirements.

OFFICE OF THE PROVINCIAL HEALTH OFFICER

KEY PROGRAM OBJECTIVE

Increase awareness and use of the provincial health goals to promote action to improve health.

PERFORMANCE MEASURE

- Assess the use of health goals by government ministries by reviewing performance plans and activities.
- Assess the use of health goals as a tool for health services planning by reviewing health services plans submitted by health authorities.

STATUS/OUTCOME

- The Provincial Health Officer conducted a review of and prepared a report on the government's activities in 2000 to determine the use of health goals. The release of the report seems to have increased awareness of the health goals in some ministries. However, more work is needed to fully adopt and implement the health goals as a template for policies and programs, and ultimately, to improve the health of the population. The Provincial Health Officer will continue to promote the health goals, supported by the multi-sectoral Advisory Committee on Health Goals for British Columbia.
- In February 2001, the advisory committee recommended that the Provincial Health Officer continue to produce reports on the use of health goals by government and other sectors.
- A survey by the Health Association of B.C. found that all health authorities are committed to using the health goals as a tool for health services planning. A September 2000 report presented the survey findings and recommended a two-year work plan for implementation and sustainability of the health goals by health authorities.

KEY PROGRAM OBJECTIVE

Increase awareness of the health status of British Columbians, the factors that influence their health and actions that can be taken to improve health.

PERFORMANCE MEASURE

- Determine number of requests for and amount of media coverage related to the Provincial Health Officer's reports.
- Determine the extent to which actions are taken on recommendations made in reports.

STATUS/OUTCOME

- The Provincial Health Officer's 1999 annual report was released in November 2000. This was the first annual report to have a written communications plan. More than 4,500 copies of the report have been distributed as of March 2001. The number of media stories and Web site "hits" have been much higher than for previous reports. Medical Health Officers continue to promote the report at the local level.
- The Provincial Health Officer's 1999 annual report recommended 22 priority actions for government. Concrete action has been taken on at least 8 of the recommendations in the areas of child care, affordable housing, early childhood development services, addiction services, protection of drinking water, improvements to primary health care, support for Aboriginal people to achieve self-governance, and expansion of immunization programs.

OFFICE OF THE PROVINCIAL HEALTH OFFICER CONTINUED

KEY PROGRAM OBJECTIVE

Increase access to information and tools for monitoring and reporting on population health, setting targets to improve health, and responding to diseases and health problems.

PERFORMANCE MEASURE

- Adopt and use a core set of indicators for monitoring population health.

STATUS/OUTCOME

- The Provincial Health Officer's 1999 annual report presented a framework and a set of 93 indicators for monitoring the health of the population. Definitions, data sources, rationale and a discussion of targets for each indicator were included. Where possible, regional data were made available in the report and electronically through the ministry's Data Warehouse.
- Indicators reported by the Provincial Health Officer are widely used by the ministry, health authorities and other health organizations and have become the de facto standard for population health reporting in B.C.
- The Office of the Provincial Health Officer participated in provincial and national initiatives to develop indicator sets for specific topics, regions and sectors. Examples include indicators for monitoring child and youth health, injury prevention and performance of health authorities.

KEY PROGRAM OBJECTIVE

Ensure that Medical Health Officers have regular feedback on the performance of their professional work.

PERFORMANCE MEASURE

- Complete an annual appraisal for each Medical Health Officer.

STATUS/OUTCOME

- All eighteen Medical Health Officers have had comprehensive, baseline performance reviews. Twelve reviews were completed in the fiscal year 2000/2001. The program objective has been revised to require comprehensive appraisals every two years, rather than annually.

OFFICE OF THE PROVINCIAL HEALTH OFFICER CONTINUED

KEY PROGRAM OBJECTIVE

Maintain inter-ministry and inter-governmental liaison for public health issues.

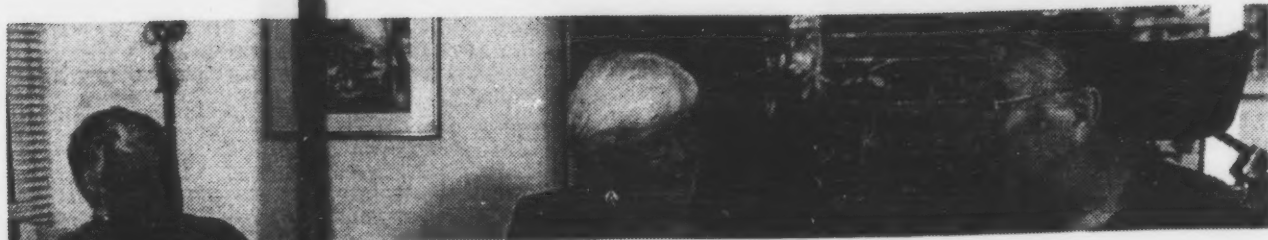
PERFORMANCE MEASURE

- Participate in the development of reports and other tools produced by inter-ministerial and inter-governmental committees.
- Determine the extent that a B.C. perspective is incorporated into federal and provincial activities and products.
- Increase the level of awareness and actions taken within B.C.

STATUS/OUTCOME

- The Office of the Provincial Health Officer participates in a wide range of inter-ministry and inter-governmental committees and working groups.
- Major reports produced in 2000/2001 included: *Reducing the Harm Associated with Injection Drug Use in Canada – Working Document for Consultation* (March 2001), prepared by a Federal/Provincial/Territorial Working Group; and *A Drug Strategy for B.C.* (June 2000) – a discussion paper by the Federal/Provincial Harm Reduction Working Group from B.C.
- A discussion paper on national priorities for injury prevention is under development and will be submitted to the conference of Deputy Ministers of Health in June 2001.
- The Provincial Health Officer has ensured that the Ministry of Health and other ministries' perspectives are included in discussions on child development, adolescent health, drinking water, injury prevention, influenza vaccine and pandemic influenza planning.
- The Office of the Provincial Health Officer makes presentations to health authorities, Ministry of Health staff and other ministries. The Office also distributes the Federal/Provincial/Territorial Working Group's publications to B.C. stakeholders.





KEY AREAS OF PERFORMANCE

PROVINCIAL HEALTH OFFICER'S REPORTS

SINCE 1993, THE PROVINCIAL HEALTH OFFICER HAS BEEN REQUIRED BY THE HEALTH ACT TO REPORT ANNUALLY ON THE HEALTH STATUS AND ON THE NEED FOR POLICY AND PROGRAMS THAT WILL IMPROVE THEIR HEALTH. SOME OF THE REPORTS PRODUCED TO DATE HAVE GIVEN A BROAD OVERVIEW OF HEALTH STATUS, WHILE OTHERS HAVE FOCUSED ON PARTICULAR TOPICS SUCH AS WOMEN'S HEALTH, CHILDREN'S HEALTH, INJECTION DRUG USE AND IMMUNIZATION.

PROVINCIAL HEALTH OFFICER'S REPORTS ARE A MEANS OF REPORTING PROGRESS TOWARD PROVINCIAL HEALTH GOALS WHICH WERE ADOPTED BY THE PROVINCE IN 1991. COPIES OF THE PROVINCIAL HEALTH OFFICER'S REPORT AND THE DOCUMENT HEALTH GOALS FOR BRITISH COLUMBIA ARE AVAILABLE FROM THE OFFICE OF THE PROVINCIAL HEALTH OFFICER.

PERFORMANCE MEASURES

This section presents key indicators that report on the health of British Columbians and both the ministry's and the health system's performance in achieving health outcomes. This section is divided into four key areas:

- **Overall health** – Measurement in areas that indicate the overall health of British Columbians in 2000/2001.
- **Accessibility** – Measurement showing the extent to which British Columbians were able to access health services they needed.
- **Quality** – Measurement in areas that indicate the quality of health services.
- **Perspectives on health spending** – Measurement of the amount spent on health care and the success of initiatives, helping ensure health spending is cost-effective.

OVERALL HEALTH

The following indicators provide a snapshot of British Columbians' health in 2000/2001. International research over the past 20 years has shown that a population's health is influenced by a number of factors outside the health care system, such as levels of income and education. Publications such as the *Provincial Health Officer's Annual Report* and the *Vital Statistics Annual Report* provide more detailed information on health status, including improvements in individual health, decrease in illness and increase in life expectancy.

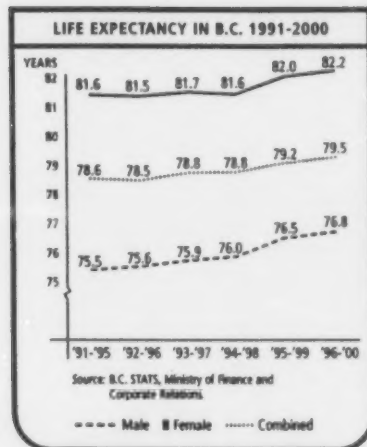
Life Expectancy

British Columbians are among the healthiest people in the country and the world. Our level of health continues to improve, although there are disparities due to income and other factors.

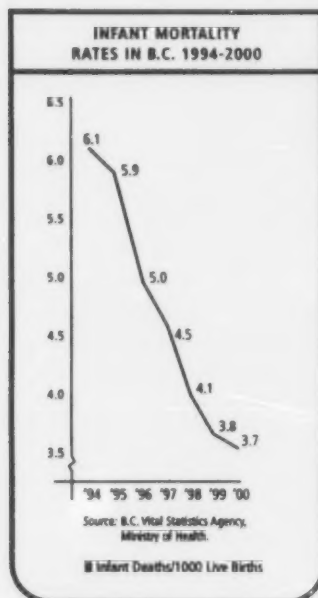
Overall life expectancy in British Columbia for 2000 has reached 76.8 years for men, 82.2 years for women and 79.5 years combined.

Infant Mortality

The infant mortality rate, an internationally accepted measure of population health, reached a record low of 3.7 per 1,000 live births in 2000 in B.C. For the province overall, fewer infants are dying in the first year of life. Early deaths due to heart disease, injuries and other preventable causes also continue to decline.



However, differences in health status persist among groups and communities in B.C. On average, infants who live in areas with lower incomes have up to twice the risk of dying before their first birthday, compared to infants in other areas of the province. This is reflected in higher rates of infant mortality among Aboriginal infants and infants born in northern areas and parts of Vancouver. Improvements



must take place if all regions and population groups are to achieve the high level of health enjoyed by the healthiest groups.

British Columbia's infant mortality rate dropped to an all-time low of 3.7 infant deaths per 1,000 live births in 2000 – a slight drop from the previous year's figure of 3.8. Since 1965, infant mortality has decreased by more than 80 per cent.

Unintentional Injuries

Up to 90 per cent of injuries are preventable if proven prevention methods are fully implemented. In 1997, the Minister's Injury Prevention Advisory Committee developed injury prevention objectives and targets for children and youth age 0-24 for whom unintentional injuries are the leading cause of death.

If the current trends continue, the 2001 targets for reductions in injury hospitalizations and deaths will be reached. Too many preventable injuries still occur, especially among children, youth, seniors, males, Aboriginal people and people living in northern and rural parts of the province.

THE INFANT MORTALITY RATE, AN INTERNATIONALLY ACCEPTED MEASURE OF POPULATION HEALTH, REACHED A RECORD LOW IN B.C. IN 2000.

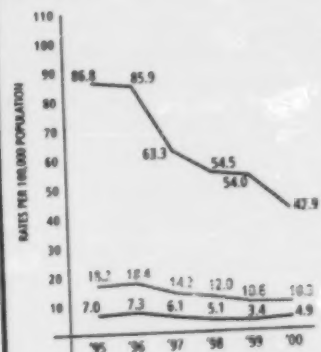
Incidence of HIV

Overall, the rate of new HIV infections has continued to decline; however, in the past year, there has been an increase in the rate of infections among men who have sex with men (MSM). In fact, in 2000 the rate for MSM (31 per cent) surpassed the rate for new infections in injection drug users (28 per cent). The reduction in rates of infection in injection drug users is in part related to continued harm reduction measures, while the increases in MSM seem to be due to an increase in risk behaviours.

The rate of HIV infection in Vancouver continues to be the highest in the province, although it did decline to 42.9 from 54.0 in 2000. There has been an increase in the rest of B.C., particularly in the Burnaby and Simon Fraser health regions.

Ongoing prevention programs and harm reduction strategies aimed at high-risk groups will continue. In particular, new initiatives will include enhanced awareness programs for men who have sex with men. In addition, it remains critical to continue to work toward decreasing new infections among injection drug users by providing access to drug treatments and taking action to address the underlying factors that place people at increased risk of HIV infection.

PERSONS TESTING NEWLY POSITIVE FOR HIV BY HEALTH JURISDICTION, RATES PER 100,000 POPULATION, B.C. 1995-2000



Source: STD Control, B.C. Centre for Disease Control. Population estimates from B.C. Stats.

■ Vancouver ■ Rest of BC ■ BC Total

Food and Waterborne Diseases

Enteric illnesses, such as Campylobacteriosis, Salmonellosis, Giardiasis and E. Coli infections, are often caused by consuming contaminated food or water. In 1999/2000, there were 5,919 confirmed reports of illness due to enteric pathogens. Studies indicate illnesses associated with enteric pathogens are underreported by a factor ranging from 39-60. Hence, in 1999/2000 the actual number of cases of these illnesses is more likely to be in the range of 250,000. Data for 2000/2001 was not available at the time of preparing this report.

Enteric illness is, to a large extent, preventable through adequate water treatment, proper food processing systems and safe food handling practices, including hand washing. New initiatives are underway to educate the public on the causes and prevention of food and water-borne illness (e.g., FightBac!) and to require industry to identify and control food preparation practices that might result in enteric illness.

Tobacco Use

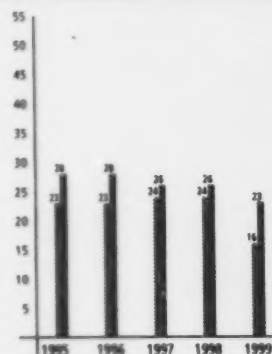
Tobacco use is the most important preventable cause of illness and death in industrialized countries. Since the 1960s, the smoking rate in British Columbia has dramatically decreased from almost 50 per cent of all adults using tobacco products to 20 per cent, the lowest smoking rate in the country. Twenty-nine per cent of young adults smoke, most of whom started before their nineteenth birthday. British Columbia's tobacco strategy aims to protect young people from starting to use tobacco, change the behaviour of the tobacco industry and hold the tobacco industry accountable for the damage its products have caused. This will be achieved through an integrated approach consisting of public education initiatives, legislation and legal action.

Provincial funding for tobacco reduction and control initiatives was maintained at \$6.5 million in 2000/2001. The Ministry of Health works closely with public health partners, health authorities and communities to implement a range of prevention, cessation and protection projects as part of B.C.'s tobacco strategy.

School-based tobacco prevention resources (bc.tobaccofacts) are available for Grades K-7 throughout the province. The Ministry continues to support the Kick the Nic program to help youth stop smoking. For the third year, students nominated from across the province have been appointed to the B.C. Youth Tobacco Attack Team. This team advises the Minister of Health on tobacco issues and provides leadership on tobacco initiatives in their communities. The team's second report, *Clearing the Air*, was published in the

summer of 2000. In January 2000, the ministry launched the second edition of *Gasp* magazine and distributed it to all grade 8 and 9 students in the province. *Gasp* magazine uses personal stories, graphic photographs, quizzes and information on cigarette contents and tobacco industry practices to motivate students to avoid tobacco. To reduce tobacco use among youth, the Ministry of Health hosted the nation's first anti-tobacco youth summit. Eighty youth from across the province attended the Kids Against Tobacco Summit (KATS) in February 2001. Youth participated in dynamic and interactive workshops aimed at motivating and inspiring young people to develop anti-tobacco initiatives in their own communities.

SMOKING RATES, AGES 15 AND OLDER, B.C., 1995 - 1999



■ Women
■ Men

Source: Canadian Tobacco Use Monitoring Survey, 2000.

Note: Data for 2000/2001 was not available at the time of preparing this report.



TOBACCO USE IS THE MOST IMPORTANT PREVENTABLE CAUSE OF ILLNESS AND DEATH IN INDUSTRIALIZED COUNTRIES. BRITISH COLUMBIA'S TOBACCO STRATEGY AIMS TO PROTECT YOUNG PEOPLE FROM STARTING TO USE TOBACCO, CHANGE THE BEHAVIOUR OF THE TOBACCO INDUSTRY AND HOLD THE TOBACCO INDUSTRY ACCOUNTABLE FOR THE DAMAGE ITS PRODUCTS HAVE CAUSED.

THE B.C. GOVERNMENT
HAS COMMITTED TO
ADDRESSING THE
THREE FACTORS THAT
DEFINE ACCESSIBILITY:
GEOGRAPHIC ACCESS,
FINANCIAL ACCESSIBILITY
AND WAITING TIMES

In January 2001, British Columbia launched *Honouring Our Health, An Aboriginal Tobacco Strategy for British Columbia*, the first of its kind in Canada. It is a community-based strategy designed by Aboriginal people to reduce tobacco use among Aboriginal peoples.

In accordance with the *Tobacco Sales Act*, the first publication of a retailer's suspension for selling tobacco to persons under the age of 19 took place in March 2001. The Vancouver retailer was suspended from selling tobacco for 24 months.

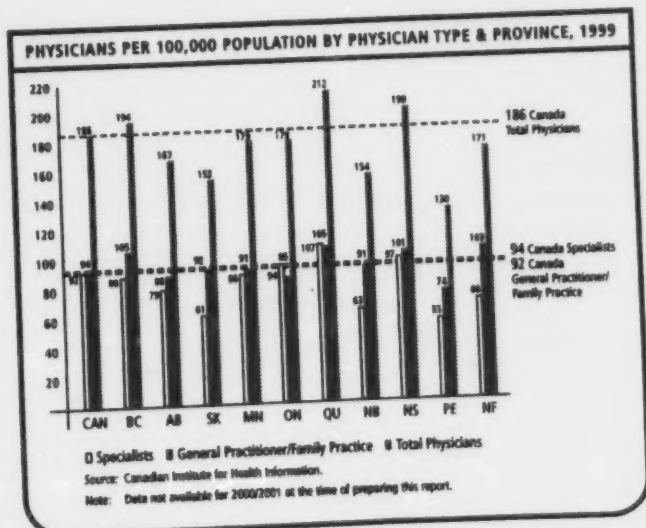
The provincial government amended B.C.'s tobacco legislation to continue its legal action against tobacco companies to recover health care costs associated with smoking.

ACCESSIBILITY

All British Columbians should receive health services that help them achieve the best possible health. Health services should be available when and where they are needed, without financial barriers.

Accessibility is one of the fundamental principles of Canada's health care system. The *Canada Health Act* and B.C.'s *Medicare Protection Act* both guarantee British Columbians ready access to physician and hospital services when they need them. Improving access to other health services has also been a priority of the B.C. government, which has committed to addressing the three factors that define accessibility: geographic access, financial accessibility and waiting times.

The performance indicators in this report have been selected to provide overall trends and an illustration of health care accessibility in 2000/2001. Both accessibility and quality of health services are closely linked and are discussed in this report.



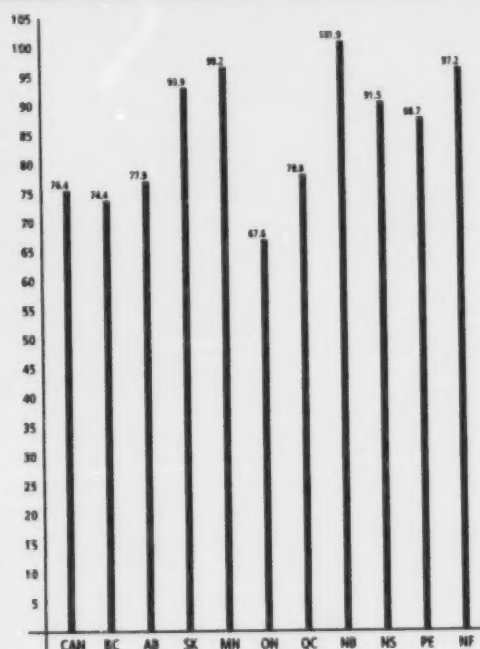
The measures presented here provide an overall picture of health service accessibility. The introduction to each section describes the limitations of using certain measures.

Human Resources

An adequate supply of qualified health professionals, such as doctors and nurses, is essential for good access to care. While higher numbers of qualified professionals might seem to indicate better accessibility to health services, this isn't always the case. There are two key limitations to using human resource data as indicators of accessibility:

- Province-wide information doesn't show variations from one part of the province to another. Generalizations based on province-wide numbers are of limited value.
- Larger numbers of a particular type of health professional do not necessarily lead to better health. Oversupply can be as much of a problem as undersupply. It can create pressure to devote more health resources to an area that might contribute less to improving health than a similar expenditure in another area of the health system.

REGISTERED NURSES AND REGISTERED PSYCHIATRIC NURSES
PER 10,000 POPULATION BY PROVINCE, 1999



■ Registered Nurses and Registered

Source: Supply and Distribution of Registered Nurses in Canada 1999 Canadian Institute for Health Information 2000; and the College of Registered Psychiatric Nurses of B.C., 2001.

Note: Data not available for 2000/2001 at the time of preparing this report.

IMMUNIZATION
PROGRAMS FOR
CHILDREN ARE
AMONG THE MOST
COST-EFFECTIVE OF
ALL HEALTH SERVICES
IN BRITISH COLUMBIA.
ALL INFANTS AND
PRESCHOOL CHILDREN
HAVE ACCESS TO
IMMUNIZATIONS TO
PROTECT THEM
FROM SEVERAL
SERIOUS DISEASES.

While views differ on what represents an adequate supply of any given profession, the figures presented here indicate that overall British Columbia is well supplied with physicians in comparison with the rest of Canada. In 1999, British Columbia had the third highest number of physicians for the size of our population, of all Canadian provinces. Quebec and Nova Scotia had higher ratios of physicians to population. B.C. had Canada's highest ratio of general practitioners to population and was slightly below the Canadian average in the ratio of specialists to population.

In contrast to British Columbia's relatively large number of physicians, the number of nurses per 100,000 population is lower in B.C. than in most other provinces. It is difficult to draw direct comparisons between provinces because each has its own unique health care system and way of utilizing nurses and other care providers. By early 1999, all provinces were beginning to feel the strain of an emerging nursing shortage and the need for a major recruitment effort.

Services Delivered

This section reports the rates at which various health services were utilized in 2000/2001, in different regions of the province and in comparison to previous years. Utilization rates indicate the proportion of the population who received a given service. For services of proven effectiveness, such as immunization and cancer screening, these rates provide useful evidence on whether services are reaching those who need them. Low rates of utilization may indicate that some regions or groups are experiencing challenges in accessing services.

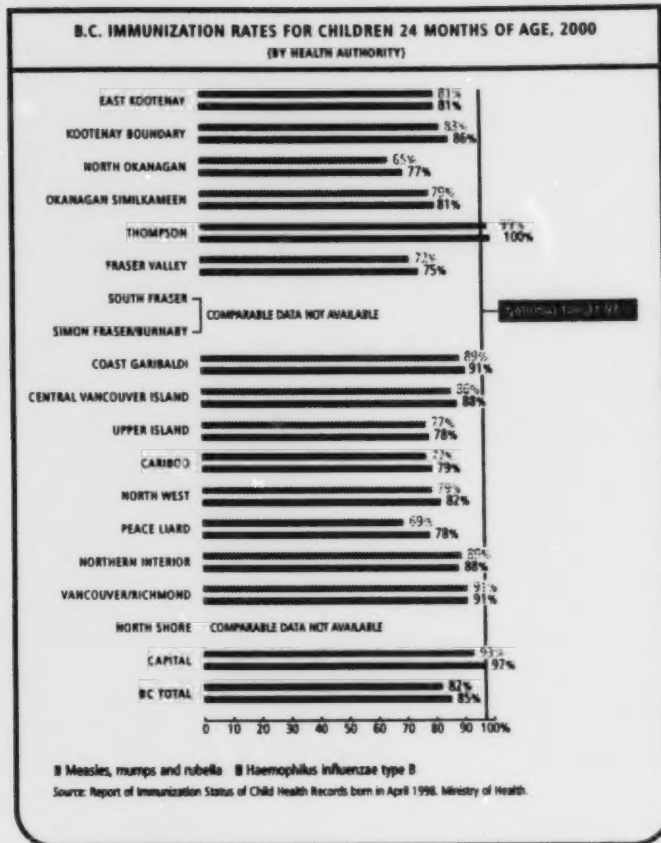
This information provides an estimate of the accessibility of services. With the exception of some diagnostic and preventative services such as immunization, higher numbers of services delivered do not necessarily indicate success in improving the health of British Columbians.

Preventive Services

Immunization Rates, Two-Year-Old Children

Immunization programs for children are among the most cost-effective of all health services. In British Columbia, all infants and preschool children now have access to immunizations to protect them from nine serious diseases. These include diphtheria, tetanus, polio, pertussis, haemophilus influenza type B, mumps, measles and rubella. In March 2001, an infant hepatitis B series was added to the routine immunization schedule.

In 2000, the majority of health authorities reported more than 80 per cent of B.C. children had been immunized by their second birthday. For some areas of the province, immunization statistics for two-year-olds are not available in part due to difficulties in gathering statistics from doctors' offices. A province-wide computerized immunization registry now in use in most areas of the province will provide more complete information on immunization statistics.



Based on the information we have available, B.C. is doing as well as other provinces in Canada in striving to meet the national immunization goals and targets. However, we need to continue strengthening our existing immunization programs to achieve 97 per cent immunization coverage rates by the age of two years.





Screening Services

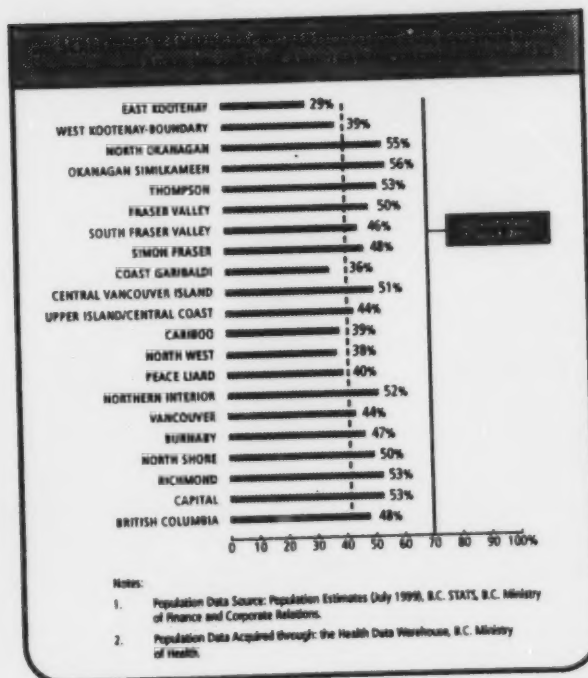
Screening Mammography

Screening mammography facilitates early detection and treatment of breast cancer. International studies have shown that screening mammography reduces death rates from breast cancer by 25 to 30 per cent if women between the ages of 50 and 69 are screened every two years.

The Screening Mammography Program of B.C. (SMPBC) began in 1988 and has expanded each year. The program detects 3.8 cancers in every 1,000 screens performed. SMPBC has extended the target age group to include women between 50 and 74.

Data indicates that women 40 to 50 and 75 to 79 may also benefit from screening. The trend is a

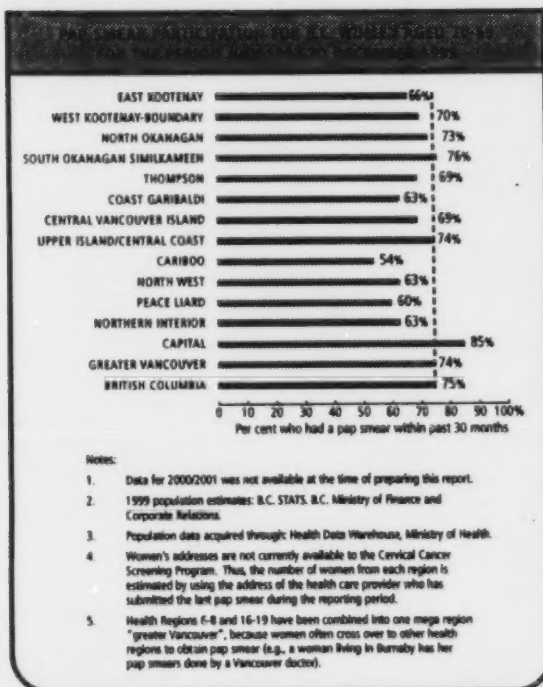
steady move toward the program's goal of screening 70 per cent of the target population, as more women attend screenings every year. Updated data indicates that 48 per cent of B.C. women in the target age group were screened by the SMPBC in 1998 and 1999. Data for the two-year period for 1999 and 2000 was not available at the time of writing this report. This data will be available August 2001.



Pap Smears

A pap smear is a sample of cells taken from the cervix of a woman's uterus. The sample is examined microscopically to identify pre-cancerous and cancerous changes. B.C. was the first jurisdiction in the world to establish an organized Pap smear program. The Cervical Cancer Screening Program (CCSP) operates a central laboratory at the B.C. Cancer Agency which receives, reviews and reports all pap smears performed in the province. The CCSP is a screening program for healthy women. Over the past 30 years, this coordinated program has been effective in reducing the incidence of invasive cancer of the cervix by 85 per cent. Deaths from cancer of the cervix have been reduced by 78 per cent in the past 50 years.

International evidence-based research supports the screening of sexually active women between the ages of 20 and 69 at least every three years. Participation rates for the CCSP are calculated as the per cent of women with at least one smear in a 30-month period. In the 30 months between July 1997 and December 1999, the participation rate among B.C. women in the target population was 75 per cent. The literature shows that participation rates vary by level of education and income. The goal of the program is to ensure that all women in the target population receive regular pap smears.



Physician Services

Many British Columbians consider the use of medical and hospital services to be a key indicator of the success of our health system. However, more use of these services does not necessarily translate to better health and, in some cases, does not indicate that they are more accessible.

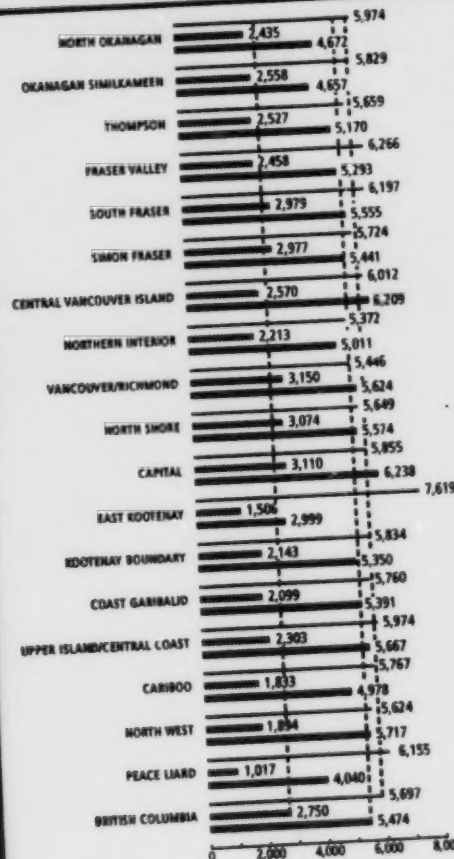
A healthier population does not necessarily use medical and hospital services more than a less healthy population.

Utilization of medical services is relatively consistent across the province¹.

The total number of urgent and emergency surgeries performed in B.C. has remained relatively stable over the last five years, despite a growing and aging population. Some of this may be attributed to alternative forms of therapy replacing surgery, such as treating some conditions with drugs or new non-invasive techniques.

¹ The utilization of services in the regions that border on Alberta — East Kootenays and Peace-Liard — are artificially low. This is because some residents in these areas use physicians located in Alberta; this is not recorded by the B.C. health system. In addition, the figures presented here do not include services paid for through the Medical Services Plan Alternative Payments program. As a result, figures are understated for some regions.

PHYSICIAN SERVICES PER 1,000 POPULATION,
BY HEALTH AUTHORITY, B.C. 1999/2000*



1 General Practitioners ■ Medical Specialists ■ Diagnostic Services

Source: Medical Services Plan

Note: Data for 2000/2001 was not available at the time of preparing this report.

*Includes fee-for-service data only.

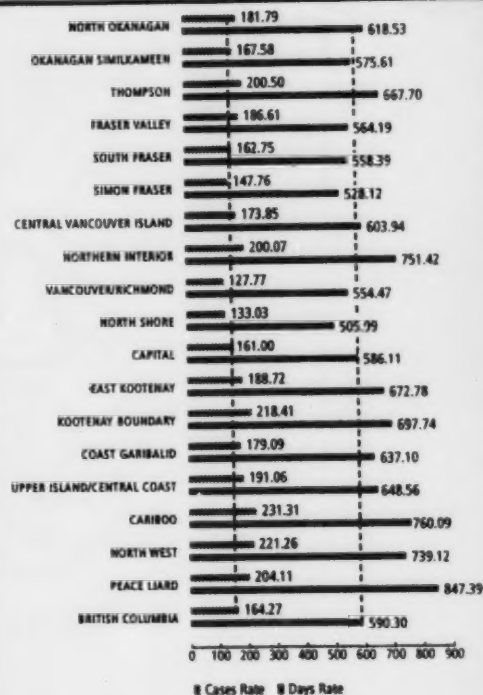
Hospital Discharge Rates

Generally, rates of hospital use have decreased over the past five years, both in terms of cases and days per thousand population. The drop in days per thousand population continues a trend that has been underway for 30 years. Province-wide, the rate of acute, rehabilitation and surgical day care utilization has declined from 174.76 cases per thousand population in 1995/1996 to 164.27 in 1999/2000.

Variation in cases and days between the regions is presented using the most recent data available. Rural areas have higher rates of cases and days per thousand population. This may reflect poorer health status, more available hospital beds and the difficulty of providing community care in some remote areas.



HOSPITAL DISCHARGE AGE-STANDARDIZED RATES IN B.C. 1999/2000
(INCLUDED DISCHARGES FROM ACUTE CARE, REHABILITATION CARE AND SURGICAL DAYCARE)



Source: PUBHSCT

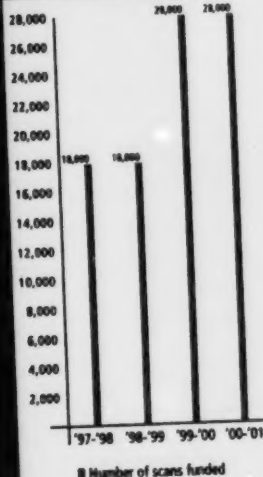
Note: Data for 2000/2001 was not available at the time of preparing this report.

Organ Transplants

The number of organ transplants that take place in British Columbia each year depends on the availability of donated organs.

Improved safety measures in B.C. have reduced the number of premature deaths and limited the supply of donated organs. As a result, there has been a strong reliance on living organ donors for kidney transplants. Mandatory referral legislation is now in place to improve the availability of organs in B.C. and reduce the wait for a transplant. Below is a chart outlining the number of organ transplants in B.C. over the last twelve years. Greater detail is available through the British Columbia Transplant Society at www.transplant.bc.ca on the Internet.

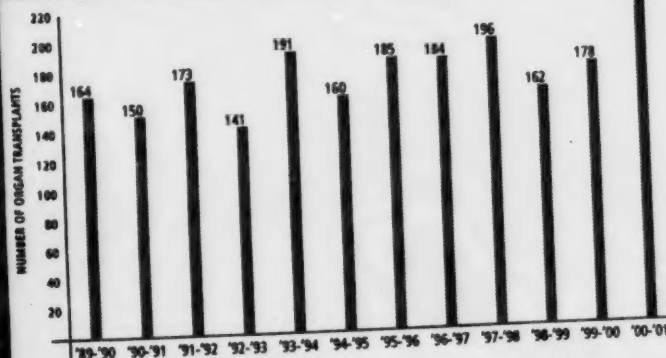
MRI SCANS FUNDED IN B.C., 1996/1997 - 2000/2001



Source: Data maintained by Regional Programs.
Note: The MRI data report only the number of scans funded by the Ministry of Health.

*In February 1999, funding for an additional 10,000 MRI scans was added, for a total of 28,000 MRI scans/year. Some MRI sites were able to increase the number of scans available in 1999/2000. Other sites required time to train technicians and did not begin delivering additional scans until 1999/2000.

SOLID ORGAN TRANSPLANTS IN B.C. 1989/1990 - 2000/2001

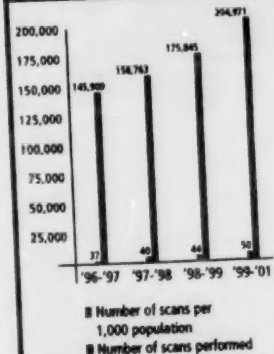


Source: British Columbia Transplant Society.

CT and MRI Technology

Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI) are sophisticated radiological techniques. CT scanning uses x-ray technology whereas MRI scanning uses electromagnetic fields. Both involve multiple images being taken and assembled by a computer to produce three-dimensional images. These imaging techniques are useful for detection of many medical conditions. The technologies are very different and each is useful for specific situations or conditions. The equipment is complex and expensive to purchase and operate. In 2000/2001, a group equipment purchase was completed for 15 CT scanners and 11 MRI scanners. These will be delivered in 2001/2002. The CT scanners include 10 replacements and 5 new scanners, resulting in a total of 34 CT scanners for the province. Of the 11 MRIs, 2 were replacements, bringing the total number of MRI scanners in the province from 7 to 17.

CT SCANS FUNDED IN B.C., 1995/1996 - 1999/2000



Source: Data are obtained by the Ministry of Health through annual survey of the sites.
Note: Data for 2000/2001 was not available at the time of preparing this report.

Pharmacare Beneficiaries and Expenditures by Plan 1999/2000 and 2000/2001

Pharmacare is the provincial drug program that helps B.C. residents pay for eligible prescription drugs and designated medical supplies. Pharmacare benefits are provided by nine different plans for target groups: seniors (Plan A), residents of long-term care facilities (Plan B), persons receiving medical benefits from the Ministry of Social Development and Economic Security (Plan C), cystic fibrosis patients (Plan D), medically-dependent children (Plan F), persons receiving premium assistance who require psychiatric medication (Plan G), in-home patients requiring oxygen (Home Oxygen Program), patients receiving treatment for HIV/AIDS

(B.C. Centre for Excellence) and all other residents of British Columbia (Plan E).

The chart illustrates Pharmacare fiscal-year expenditures and the number of beneficiaries under each plan. The expenditure amount includes payments for drug costs as well as compensation for pharmacists. The number of beneficiaries is the number of individuals who made a claim to Pharmacare that resulted in a Pharmacare payment on their behalf during the fiscal year.

PHARMACARE EXPENDITURES AND NUMBER OF BENEFICIARIES BY PLAN 1999/2000 - 2000/2001

	1999/2000		2000/2001	
	BENEFICIARIES ^{2,4,5}	EXPENDITURE ¹	BENEFICIARIES ^{2,4,5}	EXPENDITURE ¹
PLAN A	432,293	\$278,275,498	441,584	\$316,051,849
PLAN B	24,928	\$29,088,731	25,226	\$31,697,623
PLAN C	218,954	\$119,955,953	213,299	\$143,043,544
PLAN D	267	\$674,225	265	\$684,124
PLAN E	180,048	\$79,929,818	206,888	\$100,654,234
PLAN F	1,873	\$2,663,691	1,920	\$2,924,733
PLAN G	10,381	\$7,265,341	12,328	\$9,003,157
TOTAL PLANS A TO G	851,564 ⁶	\$517,853,257	883,178 ⁶	\$604,059,264
HOME OXYGEN PROGRAM	7,579	\$13,733,463 ⁷	6,749	\$14,589,629 ⁷
BC CENTRE FOR EXCELLENCE ⁴	3,432	\$30,240,190	2,793	\$31,009,026
TOTAL FOR ALL PLANS		\$561,826,910		\$649,657,919

Source Notes: 1. The 1999/2000 figures for expenditures are taken from the Ministry of Health Financial Management Report dated March 31, 2000; the 2000/2001 figures are from the Ministry of Health Financial Report Period 14 report, April 24/01. The B.C. Centre for Excellence expenditures have been increased to include post-closing 2000/2001 accrual.

2. The beneficiary counts for the Home Oxygen Program are taken from the Home Oxygen Invoice Totals Report

3. The beneficiary counts for plans A through G are taken from the Pharmacare Fiscal Year-to-date Plan Report 2000/2001

4. The beneficiary counts for the B.C. Centre of Excellence in HIV/AIDS are taken from the BCCPE March 2001 Status Report for the period 2000/2001. The B.C. Centre of Excellence in HIV/AIDS reports a decrease in beneficiaries due to a number of patients temporarily being taken off treatment.

5. The number of beneficiaries includes only those individuals with a Pharmacare paid claim in the fiscal year reported

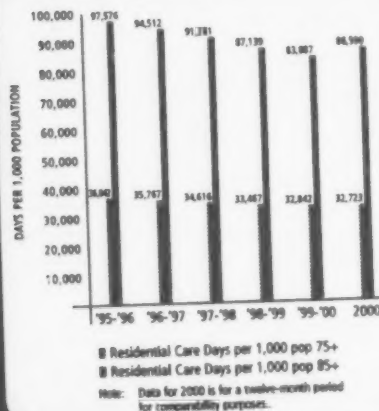
6. The sum of the PHN counts for each plan will not add up to the total PHN count for all plans because a patient can have claims adjudicated on more than one plan throughout a benefit year.

7. The Home Oxygen Program expenditure figure contains the amount for the Capital Health Region; however the number of beneficiaries in the Capital Health Region is not included in the Home Oxygen Program beneficiary count as this figure is not available through the current reporting system.

Residential and Home Care

Over the past six years, British Columbia's population aged 75 and older has grown at more than twice the rate of growth in the general population. The number of people aged 75 and older has increased by 17 per cent, and the number of people aged 85 and older has increased by 25 per cent.

**RESIDENTIAL CARE, DAYS PER 1,000
POPULATION AGE 75+ AND 85+,
B.C. 1995/1996 - 2000**



Although residential care utilization has remained nearly constant over the past six years, increased population has resulted in fewer days of care per capita. As a result, there has been an 11 per cent decrease in residential days of care per 1,000 population for people aged 75-plus and for those aged 85-plus. Because more clients with lighter care needs (Personal

Care and Intermediate Care - Level 1) were being maintained at home instead of being admitted to a residential care facility, the proportion of care days provided to clients with lighter care needs declined from 9 per cent to 1 per cent of total care days in this period. The proportion of total care days provided to clients with the heaviest care needs (Intermediate Care - Level 3 and Extended Care) increased by seven per cent over the past six years.

Direct care offers health care services to people in their homes. Services include home nursing

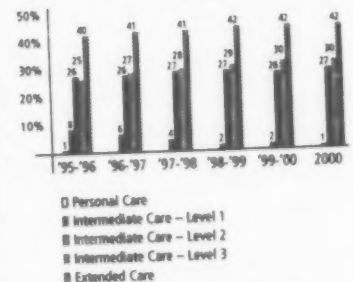
care and community rehabilitation therapy, such as physiotherapy and occupational therapy.

Direct care admissions have increased overall by 7.552 or 12 per cent over the past six years. Admissions per 1,000 population under age 75 have remained stable. In the population aged 75 and older, admissions per 1,000 population have increased by 4 per cent.

Although home support paid hours have increased slightly over the past six years, the increased population of older British Columbians has resulted in fewer paid hours per capita. There has been a decrease in paid hours per 1,000 population aged 75-plus and 85-plus by 13 per cent and 2 per cent, respectively.

In addition, there has been a shift in paid hours of services for clients with lighter care to clients with higher care needs. Over the past six years, paid hours of home support for lighter care clients

**RESIDENTIAL CARE DAYS BY LEVEL OF
CARE, B.C. 1995/1996 - 2000**



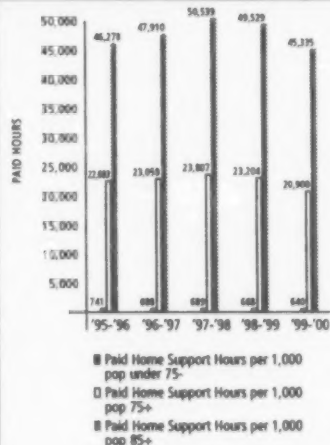
- NOTES: 1. Note that data for 2000 is for a twelve-month period for comparability purposes.
2. Residential care includes Residential, Group Homes, and Family Care Homes, and excludes Mental Health care facilities.
3. Home Support care hours exclude services authorized by Mental Health CSIL (Choice in Support for Independent Living) services are also excluded.

(Personal Care and Intermediate Care – Level 1) have decreased by 53 per cent and the number of paid hours for heavier care clients (Intermediate Care – Level 3 and Extended Care) has increased by 25 per cent.

WAITING TIMES

Waiting times for surgery, treatment and diagnostic procedures have always been a major focus of public attention. It is essential that we keep waiting times short enough to protect health and minimize pain, worry and inconvenience.

**HOME SUPPORT SERVICES UTILIZATION
PER 1,000 AGE GROUP POPULATION UNDER
75, 75+ AND 85+, BC 1995/1996 – 1999/2000***



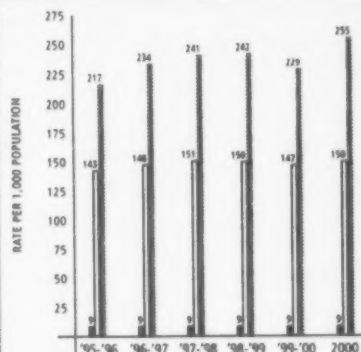
Notes: 1. These figures do not include Choice in Support for Independent Living clients (CSIL).

2. Data for 2000/2001 was not available at the time of preparing this report.

However, as with the other performance measures in this section, it is important to avoid making assumptions about waiting times. It is often forgotten that emergency cases do not go on waiting lists at all. While shorter

waiting times are preferable, waiting times for elective services do not necessarily lead to poorer health.

**DIRECT CARE ADMISSIONS PER 1,000 AGE GROUP
POPULATION BY AGES UNDER 75,
75+ AND 85+, 1995/1996 – 2000**



Source: Continuing care services data: Continuing Care Data Warehouse, April and May 2001 refresh Population P.E.O.P.L.E. 25 population estimates, BC STAIS, BC Ministry of Finance and Corporate Relations

Notes: 1. Note that data for 2000 is for a twelve-month period for comparability purposes.

2. Residential care includes Residential, Group Homes, and Family Care Homes, and excludes Mental Health care facilities.

3. Home Support care hours include services authorized by Mental Health, CSIL (Choice in Support for Independent Living) services are also included.

Some increases in waiting times can take place as a result of short-term factors and can be addressed through targeted actions. However, to reduce waiting times over the long-term, the system's capacity must be increased, which is a more complex and long-term undertaking. In making decisions about waiting times, it is important to be clear on the actual health effects of waiting times and to compare the benefits of reducing waiting times with investing the same resource in other areas of the health care system.

IT IS ESSENTIAL TO KEEP
WAITING TIMES SHORT
ENOUGH TO PROTECT
HEALTH AND MINIMIZE
PAIN, WORRY
AND INCONVENIENCE

Surgical Procedures and Treatments

An elective case is one where the patient is able to wait without damage to his or her health.

An emergency case is one in which the patient's health depends on immediate surgery. The waiting times presented in this report include only elective cases, as emergency cases proceed without patients being placed on a waiting list.

Public attention often focuses on the number of cases waiting for a particular procedure. However, for a person who is waiting, it is usually more important to know the length of the wait rather than the number of people on the list. Therefore, waiting times are used in this and other reporting by the Ministry of Health.

WAITING TIMES FOR ELECTIVE SURGICAL PROCEDURES B.C.*

	MEDIAN WAIT MAR '98	SURGERIES APR '97-MAR '98	MEDIAN WAIT MAR '99	SURGERIES APR '98-MAR '99	MEDIAN WAIT MAR '00	SURGERIES APR '99-MAR '00	MEDIAN WAIT MAR '01	SURGERIES APR '00-MAR '01
CARDIAC SURGERY	16 weeks	1,634	11 weeks	1,586	9 weeks	1,374	12 weeks	1,334
DENTAL SURGERY	4.4 weeks	5,402	5.1 weeks	5,064	7.3 weeks	5,830	6.7 weeks	6,376
EAR, NOSE & THROAT	4.1 weeks	14,997	5 weeks	13,168	6.1 weeks	14,127	6 weeks	14,662
GENERAL SURGERY	3 weeks	36,100	3.6 weeks	32,646	3.4 weeks	36,990	3.4 weeks	42,285
GYNAECOLOGY	2.4 weeks	30,188	3 weeks	27,456	3.3 weeks	28,205	3.1 weeks	29,884
NEUROSURGERY	2.7 weeks	4,009	3.1 weeks	3,478	3.6 weeks	4,247	3.3 weeks	4,522
OPHTHALMOLOGY	2.7 weeks	26,779	8.1 weeks	22,193	8.9 weeks	26,087	10.6 weeks	30,432
ORTHOPEDICS	6.1 weeks	26,779	8.1 weeks	25,423	6.9 weeks	27,049	7 weeks	29,111
PLASTIC SURGERY	5.4 weeks	27,329	7.3 weeks	25,423	5.4 weeks	8,527	5.4 weeks	8,778
UROLOGY	6.5 weeks	8,344	7.6 weeks	7,776	4.1 weeks	23,199	4.1 weeks	24,449
VASCULAR SURGERY	2.9 weeks	24,382	3.1 weeks	22,143	1.4 weeks	3,958	2.1 weeks	4,027

*Median wait is based on procedures performed over the previous 6 months. Data is taken from the Surgical Wait List Registry. The data includes booked surgeries for hospitals participating in the Registry. It does not include emergency surgeries since these are not booked.

A total of 402,230 surgical procedures were performed in B.C. during 1999/2000. Of these, 380,108 were elective and the remaining 22,122 were emergency. It is estimated the total number of surgical procedures for 2000/2001 will rise to 407,060. Data was not available at the time of preparing this report.

As the charts indicate, the median wait time for most surgeries in B.C. decreased or remained the same from the previous year. The median wait time for cardiac surgery increased following two years of significant declines. The shortage of specialized nurses resulted in fewer cardiac surgeries being performed this year in comparison to last year.

NON-EMERGENCY CARDIAC SURGERY WAIT TIMES B.C., 1995/1996 - 2000/2001

	MARCH 1996	MARCH 1997	MARCH 1998	MARCH 1999	MARCH 00	MARCH 01
Median wait (in weeks)	10	16	16	11	9	12

CATARACT SURGERY WAIT TIMES B.C., 1996/1997 - 2000/2001								
	Median Wait EAR '96	Surgeries APR '97-DEC '98	Median Wait EAR '99	Surgeries APR '99-DEC '99	Median Wait EAR '00	Surgeries APR '00-DEC '00	Median Wait EAR '01	Surgeries APR '01-DEC '01
Cataract Surgery	8.1 weeks	21,442	9.6 weeks	19,648	10.3 weeks	22,320	11.7 weeks	25,541
HIP REPLACEMENT WAIT TIMES B.C., 1996/1997 - 2000/2001								
	Median Wait EAR '96	Surgeries APR '97-DEC '98	Median Wait EAR '99	Surgeries APR '99-DEC '99	Median Wait EAR '00	Surgeries APR '00-DEC '00	Median Wait EAR '01	Surgeries APR '01-DEC '01
Hip Replacement Surgery	9.4 weeks	2,216	14.6 weeks	2,027	17 weeks	2,366	17.9 weeks	2,441
KNEE REPLACEMENT WAIT TIMES B.C., 1996/1997 - 2000/2001								
	Median Wait EAR '96	Surgeries APR '97-DEC '98	Median Wait EAR '99	Surgeries APR '99-DEC '99	Median Wait EAR '00	Surgeries APR '00-DEC '00	Median Wait EAR '01	Surgeries APR '01-DEC '01
Knee Replacement Surgery	11.7 weeks	2,046	18.6 weeks	1,973	19.6 weeks	2,464	21.6 weeks	2,577
CORNEAL TRANSPLANTS WAIT TIMES, B.C. 1996/1997 - 2000/2001								
	Median Wait EAR '96	Surgeries APR '97-DEC '98	Median Wait EAR '99	Surgeries APR '99-DEC '99	Median Wait EAR '00	Surgeries APR '00-DEC '00	Median Wait EAR '01	Surgeries APR '01-DEC '01
Corneal Surgery	6 months	487	5 months	503	5 months	422	5.2 months	573

The median wait times for high demand surgical procedures such as hip and knee replacements continued to climb, in spite of increased funding targeted to these procedures.

In 2000/2001, the number of surgeries performed for all procedures increased except for cardiac surgery. For some procedures these increases were quite dramatic.

The number of cataract surgeries and hip and knee replacement surgeries performed in 2000/2001 increased from previous years, yet the median wait time continues to increase. This is an indication of the demand for the procedures.

Waiting times for corneal transplants depend to a great extent on the availability of corneal tissue. Despite a shortage of tissue supply, the Corneal Transplant Program has been able to reduce

the waiting time and increase the number of surgeries performed over the past number of years.

Many factors can account for wait time increases, including increases in emergency services and availability of staff or operating room time. Health authorities and the Ministry of Health routinely monitor wait times and, when necessary, intervene by providing funding to address wait time peaks, rescheduling operating room arrangements or taking other administrative measures to increase surgical throughput.

Half of all heart surgery patients in B.C. receive their surgery on an emergency basis. For the other half of patients, surgically classified as non-urgent cases, B.C. has a well-developed cardiac registry that monitors wait lists, wait times and treatments for cardiac disease.





With the combined efforts of the cardiac registry and increased funding for cardiac procedures, the March 2000 median wait time was the shortest it had been in more than four years. Unfortunately, the shortage of specialized nurses resulted in an increase in the median wait time in March 2001.

Waiting time for cancer radiation therapy decreased to the lowest level in the past four years. At the same time, the number of courses of treatment increased by over 20 per cent from 1997/1998. The opening of the new and expanded cancer clinic in Victoria this year will provide greater access to radiotherapy services to people living on Vancouver Island.

Radiation therapy is provided by the B.C. Cancer Agency at four centres in the province: Vancouver, Surrey, Victoria and Kelowna. Nearly 65 per cent of British Columbians start radiotherapy within four weeks of referral by a radiation oncology therapist. The median wait time was 8 days at the end of the 2000/2001 fiscal year. Improved access to radiotherapy services has been achieved by constructing a new and expanded clinic in Victoria and by adding a fifth radiotherapy machine in Surrey.

Chemotherapy services are provided throughout the province. In addition to services administered at the four major cancer centres, chemotherapy is available in 19

community centres. The standard for chemotherapy wait times is two weeks and this standard is met in almost every case.

Another element of cancer waiting times is the time a patient must wait to see an oncologist.

Emergency

British Columbia Ambulance Service

In 2000/2001, the average response time to the most urgent ambulance or Delta calls in the City of Vancouver was 8.7 minutes. The average response time to Delta calls in the Greater Vancouver Regional District was 9.4 minutes.

The B.C. Ambulance Service (BCAS) continued to work on operational strategies aimed at reducing response times while the provincial total incident volume increased 2.9 per cent over the year. During this period, our ambulances continued to experience frequent delays in the unloading of patients at the emergency wards of hospitals in the Lower Mainland and with increasing frequency in other areas. In December 1999, the BCAS implemented a temporary strategy of locating paramedic staff at the busiest hospital emergency wards to assist ambulance crews to return to active emergency coverage more quickly. This system in part mitigated increased overall response times, especially during periods of peak demand.

CANCER RADIATION THERAPY WAIT TIMES B.C., 1997/1998 - 2000/2001

	MEDIAN WAIT MAR '98	COURSES OF TREATMENT APR '97-MAR '98	MEDIAN WAIT MAR '99	COURSES OF TREATMENT APR '98-MAR '99	MEDIAN WAIT MAR '00	COURSES OF TREATMENT APR '99-MAR '00	MEDIAN WAIT MAR '01	COURSES OF TREATMENT APR '00-MAR '01
Radiation Therapy	1.4 weeks	8,268	1.6 weeks	8,840	2 weeks	9,782	1.3 weeks	10,063

The BCAS also implemented the Advanced Medical Priority Dispatch System in the three Regional Dispatch Centres. This system has given dispatchers an improved and more accurate method of assessing medical emergency calls and determining the correct level of response. Compliance to the Advanced Medical Priority Dispatch System protocol exceeded 90 per cent for fiscal year 2000/2001.

QUALITY

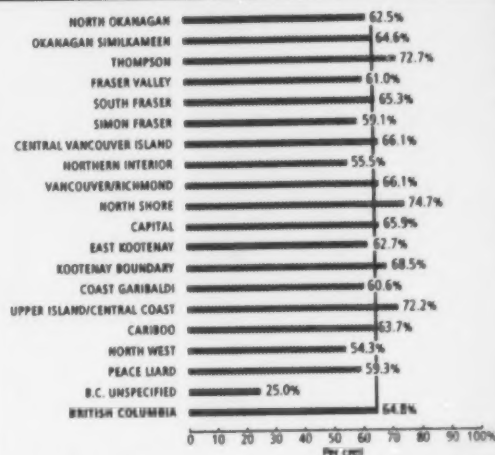
British Columbians expect quality health services when they need them. The quality of health services depends on the skills of the providers, the facilities and equipment used and on the organization and administration of the services.

The meaning of the term 'quality' and how to measure it are matters of opinion. Quality means different things to different people. Some would measure quality by the perceptions of people who use the system. Others would use statistical measures of efficiency. Still others would focus on the assessment of health outcomes.

Many current indicators and measurements of quality have been used. The Canadian Institute of Health Information (CIHI) has determined that no single measure of quality exists and that the best approach is to use a variety of quality indicators.

The following indicators are relatively simple and are presented as examples of how we might measure the quality of our health system. The ministry is working to develop indicators across service lines to provide a comprehensive, meaningful picture of service quality in the future.

BREAST CONSERVING SURGERY AS PER CENT OF ALL FEMALE BREAST CANCER SURGERY, 1999/2000



Source: Morbidity database, Information Support Branch, Ministry of Health
Note: Data for 2000/2001 was not available at the time of preparing this report.

Breast-Conserving Surgery

Breast cancer is the most common cause of death due to cancer in women. The treatment of breast cancer depends on how far it has spread. It is now considered preferable to treat localized cancer with breast-conserving surgery rather than complete mastectomy. Studies have shown that women who have breast-conserving surgery followed by radiation therapy have the same survival rates as those undergoing complete mastectomy. Breast-conserving surgery is a more desirable practice and a less traumatic treatment, both physically and psychologically. Increased use of breast-conserving surgery is considered an indicator of improved health care quality.

In Canada, the rate of breast-conserving surgery is reported by the Canadian Institute for Health Information. The level of breast-conserving surgery as a proportion of all cases of breast cancer has changed little over the past five years.

The rate of breast-conserving surgery has risen from 62 to 65 per cent, according to the most recent data available².

² Source: Canadian Institute for Health Research, Hospital Discharge Abstract Database, Ministry of Health.

Outcomes

B.C. has better survival outcomes for cancer treatment than any other Canadian province, partly due to the fact that these services are coordinated and delivered by a central agency. As a result, consistent treatments can be provided to cancer patients across the province, according to published protocols.

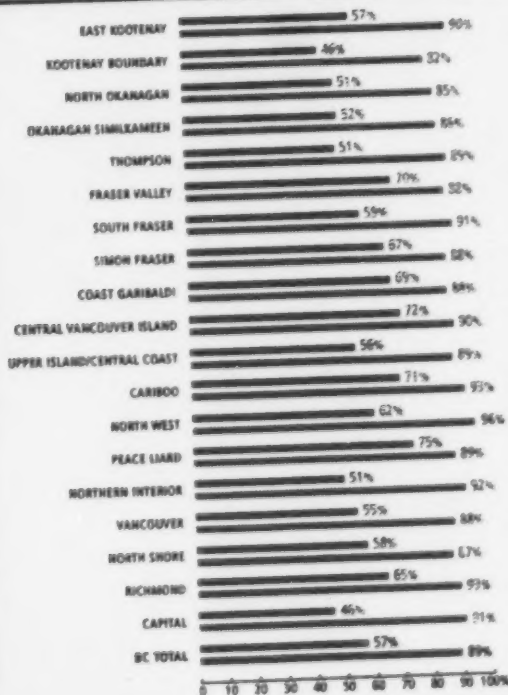
An excellent example of such treatment outcomes is the greatly reduced recurrence rate of early stage lymphoma (primary cancer of the lymph glands). The recurrence rate is about 22 per cent worldwide, but in B.C. the recurrence rate is only one per cent.

Immunization for Seniors

Each year in Canada, influenza is a major cause of illness, hospitalization and death among older persons and certain persons with chronic health conditions. An effective influenza vaccine is available to prevent the spread of the influenza A and B virus and is offered at no charge to select high-risk groups each fall. When administered to persons residing in care facilities, the vaccine has been shown to be 30 to 40 per cent effective in preventing illness, 50 to 60 per cent effective in preventing hospitalization and pneumonia, and up to 85 per cent effective in preventing death. Influenza immunization of health care workers also reduces the risk of outbreaks in care facilities.

For the 2000/2001 influenza season, the Ministry of Health, in partnership with the B.C. Centre for Disease Control and health authorities, planned a comprehensive campaign to increase immunization rates in British Columbia and reduce pressures on hospital emergency rooms during influenza season. The provincial government provided additional funding to support the program and assist health authorities to enhance their programs. The 2000/2001 influenza statistics showed that immunization rates had increased in three targeted areas. Eighty-nine per cent of residents in care facilities were immunized with some regions surpassing the 90 per cent national target. Rates of

CARE FACILITIES IMMUNIZATION RATES 2000/2001



■ Per cent of Health Care Workers Immunized ■ Per cent of Residents in LTC Immunized
Source: Appendix G, Influenza Report for B.C. 2000/2001, Ministry of Health.

immunization for health care workers increased to 57 per cent, and rates for individuals 65 years and over living in the community increased to 71 per cent. We must continue to build on these successes as we strive to meet the benchmark of 80 per cent for health care workers and community residents 65 years and older.

For pneumococcal immunization, a one-time dose provides life-long protection for most people. Publicly-funded pneumococcal vaccine for all people 65 and older began in April 1998 and is available year round. Based on vaccine uptake, it is estimated that 40 per cent of individuals 65 years and older have received the vaccine to date.

Mental Health Re-admissions to Hospitals

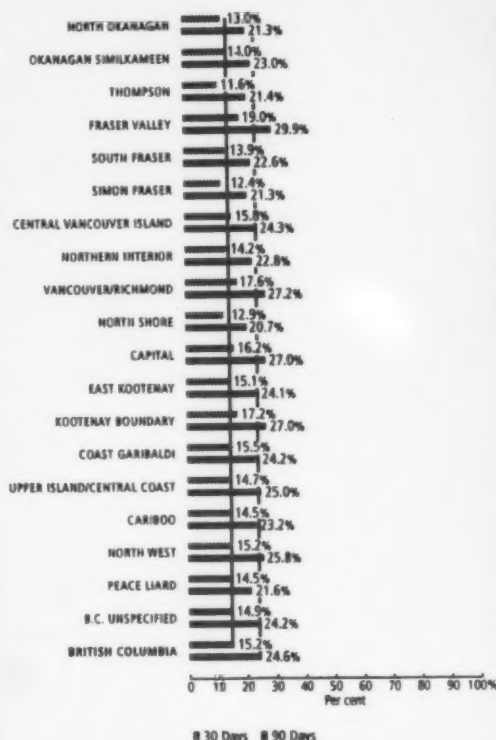
Severe mental health disorders, such as bipolar disorders and schizophrenia, are the most common reasons for admission to hospital with a diagnosis related to mental health.

While admission may be necessary for acute treatment, most patients can be well-maintained in the community with regular follow-up and support services. Lower rates of re-admission to hospital soon after discharge are considered to be an indicator of improving health care quality.

The chart shows the re-admission percentages for patients discharged from hospital with a principal diagnosis of severe mental illness.

The most recent data available indicates that there were 20,443 discharges provincewide in 1999/2000. Of the total, 15.2 per cent were readmitted within 30 days, another 5.7 per cent within 60 days and a further 3.7 per cent

MENTAL HEALTH ACUTE RE-ADMISSIONS, 1999/2000



- Notes:
1. Data for 2000/2001 was not available at the time of preparing this report.
 2. Includes hospital separations for all levels of care with the exception of day surgery.
 3. Hospital separations for out-of-province residents are excluded.
 4. Hospital separations are based on a primary diagnosis being an ICD9 code between 290 and 314, V61 or V62.
 5. Hospital separations with a PPH of 0 are excluded from this data.
 6. Hospital separations and admissions for the same client that occurred on the same day and excluded to be consistent with re-admission data which uses the same client.
 7. B.C. residents that are treated in other provinces are excluded.
 8. Grouping by Health Authority is based on RMBCHSS of the client at the time of hospital discharge.
 9. The readmission data may be incomplete as not all hospitals have reported the first 90 days of 2000/2001.



within 90 days. There is considerable variation among regions. In six regions, 25 per cent or greater of discharged mental health acute care patients were readmitted within 90 days. In all regions, the majority of re-admissions occur within 30 days following discharge from hospital. Regional breakdowns do not support a suggestion that there might be a trade-off relationship between availability of community mental health services and hospital re-admission³.

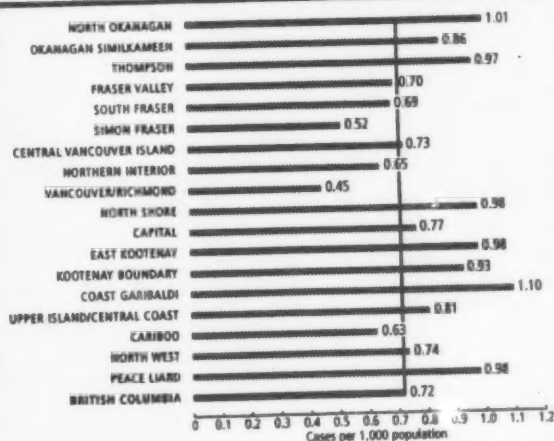
³ Source: Canadian Institute for Health Information, Hospital Discharge Abstract Database, Ministry of Health.

Hip Replacement Surgery

Over the past several years, the rate of hip replacement in B.C. has remained relatively stable at 0.6 to 0.7 cases per 1,000 population. The most recent data available is for 1999/2000 and, as the table indicates, regions varied widely in hip replacement surgery rates: 0.4 cases per 1000 population in the Vancouver/ Richmond region, 0.5 cases per 1,000 population in Simon Fraser, 1.0 per 1000 in the North Okanagan, and 1.1 per 1,000 population in the Coast Garibaldi region. This degree of variation has persisted throughout the years. Similar levels of variation are found in Ontario but are not statistically significant⁴.

⁴ van Walraven C, Paterson JM, Kapral M, Chan B, Bell M, Hawker GA, et al. Appropriateness of primary total hip and knee replacements in regions of Ontario with high low utilization rates. *Can Med Assoc J.* 1996; 155(6):697-706.

**HIP REPLACEMENT SURGERY RATE, B.C., 1999/2000
(CASES PER 1,000 POPULATION)**



Source: Discharge Abstract Database

Note: Includes out of province cases. (i.e. B.C. residents treated out of province)

Data for 2000/2001 not available at the time of preparing this report.

There is no significant difference between rural and urban areas in the rates of surgery, although residents of the Lower Mainland generally have a rate at or below the provincial average, whereas those living elsewhere have rates at or above the provincial rate.

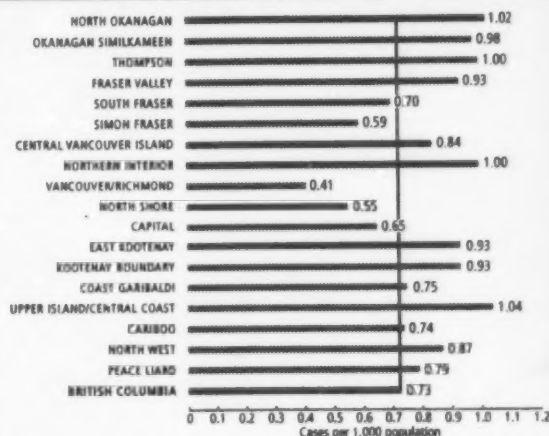
Knee Joint Replacement Surgery

The most recent data available indicates that the rate of knee replacements was 0.7 in 1999/2000. The number of cases increased from 2,291 in 1995/1996 to 2,918 in 1999/2000 – an increase of 27 per cent. Lengths of hospital stay dropped steadily from 7 days in 1993/1994 to 5 days in 1998/1999, with a slight increase in 1999/2000 to 5.7 days.

As with hip replacement surgery, regions varied in their utilization rates in 1999/2000: 0.41 cases per 1,000 population in Vancouver/Richmond; 1.0 per 1,000 in the Northern Interior; 1.02 in North Okanagan; and 1.04 in Upper Island/Central Coast. Major population centres in the Lower Mainland and Victoria had rates below the provincial average, while rural regions had rates above the provincial average⁵.

⁵ Source: Canadian Institute for Health Information, Hospital Discharge Abstract Database, Ministry of Health.

KNEE JOINT REPLACEMENT SURGERY RATE, B.C. 1999/2000
(CASES PER 1,000 POPULATION)



Notes: 1. Data for 2000/2001 not available at the time of preparing this report.
2. Includes out of province cases.



Cataract Surgery

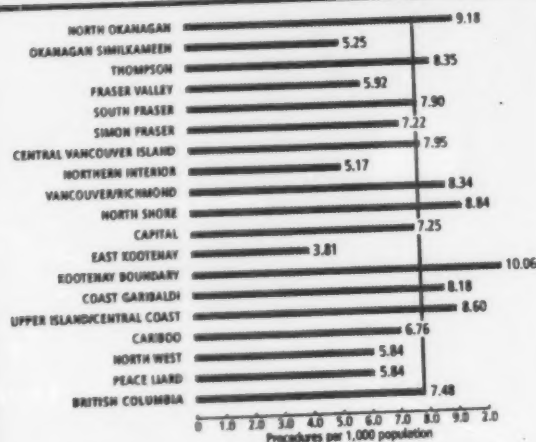
Cataract surgery is the removal of a clouded lens from one or both eyes and the insertion of an artificial lens. This improves eyesight considerably. Clouding of the lens is a condition that becomes more common as people grow older. There is no known way to prevent most cases of this condition. As techniques have improved over the years, the procedure has changed from being performed as an inpatient procedure to being performed on an outpatient basis.

According to the most recent data, the rate of cases has risen from 5.46 per 1,000 population in 1993/1994 to 7.48 per 1,000 in

1999/2000. The rate will likely continue to rise over the next number of years as the population ages and demand increases. Variation among regions ranges from 3.81 per 1,000 in East Kootenay to 10.06 cases per 1,000 in the Kootenay Boundary region.

Lower rates in the East Kootenay region can likely be explained by the fact that day care surgeries carried out on B.C. residents in Alberta facilities are not included in these figures.

CATARACT SURGERY RATE
(PROCEDURES PER 1,000 POPULATION) 1999/2000



Source: Canadian Institute for Health Information, Hospital Discharge Abstract Database, Ministry of Health.

Note: Data for 2000/2001 not available at the time of preparing this report.

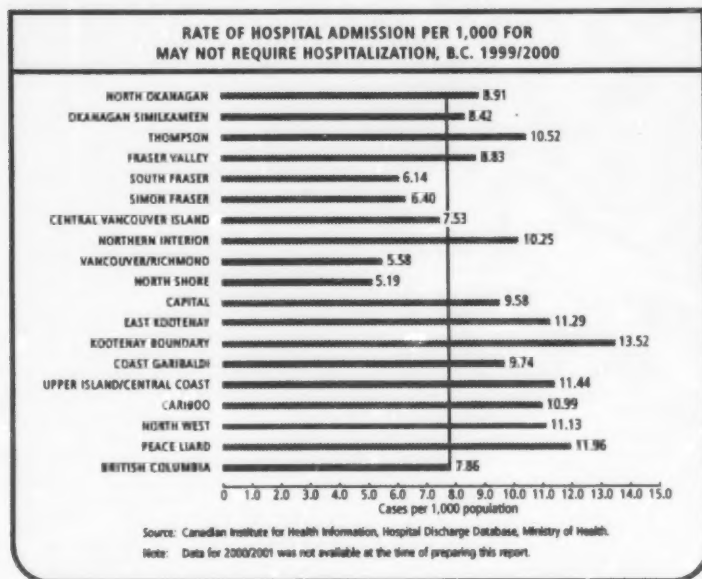
Admission to Hospital for May Not Require Hospitalization (MNRH) Conditions

By analyzing all the cases discharged from hospitals throughout Canada, the Canadian Institute for Health Information (CIHI) regularly identifies cases that may not require admission to hospital as an inpatient. A May Not Require Hospitalisation (MNRH) is a case where a patient is admitted to hospital even though the patient may have been treated on an ambulatory basis. A lower rate of admission to hospital for MNRH conditions is considered to be an indicator of improving health care efficiency. The data indicates a consistently dropping rate of MNRH cases per 1,000 population over five years.

This would be consistent with continued efforts to avoid unnecessary hospitalization.

In addition to dropping in absolute terms, MNRH cases have dropped as a percentage of all inpatient cases from 10.1 per cent in 1995/1996 to 8.07 per cent in 1999/2000, according to the most recent data.

Variation among regions is relatively high, with a rate of 5.19 cases per 1,000 population in the North Shore region and 13.52 cases per 1,000 in the Kootenay Boundary Region in 1999/2000.





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FINANCIAL SUSTAINABILITY

The overall level of health care spending has long been viewed as a sign of the relative health of the system. However, health does not necessarily improve because more is spent on health care. The fiscal challenges facing all governments make it essential that we make more effective use of health resources rather than simply equating higher spending with success. By reducing unnecessary or inappropriate use of health services, more resources are available for programs and services that do make a positive difference to the health of British Columbians.

This section includes examples of both approaches to measuring success in terms of health spending: simple measures of dollars spent and an example from the Medical Services Commission of influencing the appropriateness and effectiveness of spending.

The Effect of Guidelines and Protocols

The Medical Services Commission (MSC) has adopted clinical practice guidelines and protocols that improve care and reduce unnecessary or inappropriate use of doctors' services, thereby making more resources available for services that make a real positive difference to people's health. This guideline and protocol initiative is an example of the ministry working with physicians, surgeons and other medical practitioners to review and provide practitioners with the best available information on appropriate care for common situations.

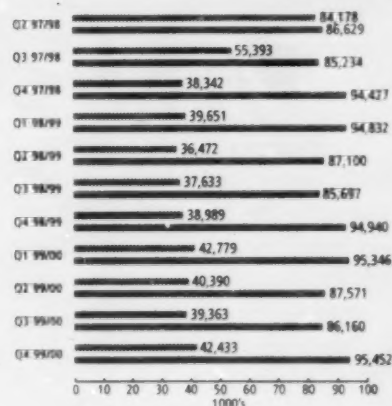
An example of the effectiveness of this approach is the Erythrocyte Sedimentation Rate test, where a new protocol reduced the number of tests that needed to be carried out. This was accomplished by recommending that physicians only order the test when it is useful, rather than routinely. This freed up resources for other needed medical services. The cost per Erythrocyte Sedimentation Rate test is \$2.25. In 1996/1997, the year prior to the introduction of the protocols, there were 344,687 paid services for this test. In 1999/2000 this number was reduced to 166,171 paid services. The cost in 1996/1997 was \$775,545; in 1999/2000 this had shrunk to \$372,223 - a cost reduction of 48 per cent.

There are 32 protocols and guidelines currently in effect, covering a wide range of medical services, such as routine pre-operative testing and prenatal ultrasound. The four new guidelines or protocols approved and introduced in 2000/2001 included: office and laboratory

management of genital specimens; investigation of suspected infectious diarrhea; diagnosis and management of sore throat; and use of homocysteine measurement in the evaluation of atherothrombotic disease. Medical Services Plan (MSP) expenditures on the medical diagnostic and treatment services that may be affected by the new guidelines totalled approximately \$25 million in 1999/2000. Five more of the existing protocols or guidelines were revised and updated during the year.

While not all guidelines and protocols result in reduced costs, and in some cases they may increase utilization, the overall impact of this initiative has been a more appropriate use of resources. The MSC and the British Columbia Medical Association (BCMA) are currently working on further guidelines to maintain this initiative.

ESTIMATED REDUCED UTILIZATION AND EXPENDITURE DUE TO PROTOCOL FOR ERYTHROCYTE SEDIMENTATION RATE 1999/2000



■ Actual Utilization ■ Projected Utilization

Source: Discharge Abstract Database.

Note: Data for 2000/2001 not available at the time of preparing this report.

B.C. Government Health Care Spending

The following charts present the amount spent on health care in British Columbia in 1998/1999 and 1999/2000. The Ministry of Health expenditures increased by 7.9 per cent during 1999/2000 to \$7.97 billion. In addition, other ministries spend money on health care. The chart indicates that other ministries spent \$310 million on health care, based on data from the Canadian Institute for Health

Information (CIHI). For the same time period, CIHI data examines the levels of other public sector expenditures such as municipal and federal government direct spending on health care. Furthermore, CIHI data examines private sector contributions to total health care spending, such as commercial and not-for-profit insurance plans and out-of-pocket expenses.

HEALTH CARE SPENDING IN B.C. (MILLIONS OF DOLLARS) 1998/1999 - 1999/2000*

	MINISTRY OF HEALTH	OTHER B.C. GOVERNMENT MINISTRIES	OTHER PUBLIC SECTOR	PRIVATE SECTOR	TOTAL
1998/99	\$7,383	\$456	\$558	\$3,303	\$11,700
1999/00	\$7,965	\$310	\$589	\$3,349	\$12,213
PERCENTAGE CHANGE (%)					
1999/00	7.9%	-32.1%	5.6%	1.4%	4.4%

Source: Canadian Institute for Health Information calendar year data for columns Provincial Government, Public Sector, Private Sector and Total have been converted from calendar years to fiscal years for comparison purposes.

Note: Data for 2000/2001 not available at the time of preparing this report.

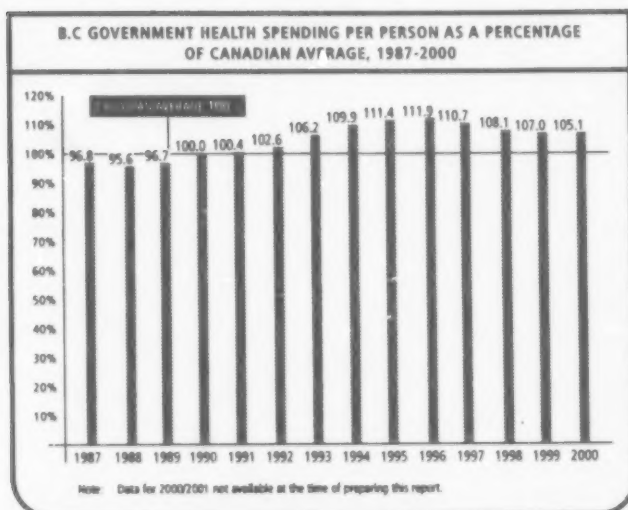
HEALTH CARE SPENDING IN B.C. (DOLLARS PER PERSON) 1998/1999 - 1999/2000

	MINISTRY OF HEALTH	OTHER B.C. GOVERNMENT MINISTRIES	OTHER PUBLIC SECTOR	PRIVATE SECTOR	TOTAL
1998/99	\$1,843	\$114	\$139	\$825	\$2,921
1999/00	\$1,973	\$77	\$146	\$830	\$3,025
PERCENTAGE CHANGE (%)					
1999/00	7.0%	-32.7%	4.7%	0.6%	3.6%

Note: Data for 2000/2001 not available at the time of preparing this report.

National Comparison

The following table shows the British Columbia provincial government's per person spending on health as a percentage of the Canadian average. Over a sixteen-year period, B.C. moved from below the Canadian average to consistently above average in health spending.







MINISTRY KEY EVENTS

PROTECTING MEDICARE AND ESSENTIAL HEALTH SERVICES

■ Increased Health Care Funding

– The Ministry of Health received increased funding in 2000/2001 to ensure quality, accessible and affordable health care services for all British Columbians.

- Over the last decade, B.C. has increased health care funding by \$3.4 billion or 62 per cent. The Ministry of Health's budget increased to \$8.8 billion for the 2000/2001 fiscal year – an increase of almost 14 per cent over the previous year. Priorities for new funding included recruiting more health care professionals, upgrading facilities, purchasing new equipment and enhancing health service delivery.
- The federal government provides funding for provincial health services through the Canada Health and Social Transfer, a block fund in support of health care, post-secondary education and social services. In 2000/2001, 14.6 per cent of provincial health expenditures were covered by the federal transfer and funding was provided by the B.C. Ministry of Finance and Corporate Relations.
- Funding of \$5.06 billion was allocated to local health authorities to deliver acute and continuing care, mental health services and preventive health services for the year. Increased funding was provided for new equipment, more cancer treatments, renal services and cardiac programs. Funding was also provided for new long-term care beds and more home support services to help reduce demands on acute care hospital beds. The ministry provided additional funding for mental health services – for community support, crisis response and stabilization services – for people with serious mental illness as an alternative to hospitalization.
- New funding of \$3 million was provided to health authorities to implement an enhanced influenza strategy to reduce influenza-related illnesses among the most vulnerable populations.
- A comprehensive hepatitis strategy was also introduced to reduce the incidence of viral hepatitis and to improve access to and quality of care for those infected. Funding of \$5 million was allocated for the hepatitis prevention strategy. The strategy includes: a universal infant and child catch-up hepatitis B immunization program for all newborns and children living in high-risk households with hepatitis-positive people; expansion of the hepatitis A vaccination program to protect people at increased risk from hepatitis A infection; creation

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of a Hepatitis Secretariat to coordinate hepatitis information and services; and, enhanced laboratory testing and better integration of data.

- The ministry provided \$141 million to help hospitals buy new medical equipment and high-tech diagnostic equipment such as Magnetic Resonance Imaging (MRI) and Computerized Tomography (CT) scanners, modern clinical equipment for operating rooms and labs, and new beds and lifts to prevent injuries to health care workers.
- In September and December 2000, government approved an additional \$502 million to fund health services, including strategic investments by the Ministry of Health to improve health care in B.C. New initiatives resulting from this funding included the following:
 - The ministry provided \$9.4 million for four new grant programs to reduce nursing shortages and improve working conditions for nurses in B.C.'s health care system. These grants support nurses in the workplace, help train and mentor nursing students and new nurses, and bolster recruitment and retention of nurses in rural communities.
 - The government invested over \$3.5 million to enable the B.C. Ambulance Service to address paramedic workload issues through the creation of new paramedic positions and expansion of the regional training network.
 - An additional \$28 million was allocated to meet increased demands for ambulance services and specialized acute services such as renal treatment, cancer drugs and transplant services. This funding was also allocated for growth in Medical Services Plan billings and services.
- Funding of \$25.8 million was allocated to better serve people requiring specialized services such as tertiary care. This funding will enhance cardiac, cancer, renal, trauma and transportation services.
- The \$1 million B.C. Health Care Scholarship provides financial support to health care workers for upgrading and retraining. Medical laboratory technologists, medical radiation technologists, physical therapists and other health care professionals can apply for bursaries.
- The ministry allocated \$8.9 million to health authorities to create extra capacity to relieve seasonal pressures and reduce backlogs of patients waiting for admission in peak periods.
- New funding will enable the ministry to work with health authorities and care providers to establish a new province-wide bed management system. This will provide a 24-hour referral service for physicians linking critical care beds with emergency admission needs for seriously ill patients in B.C.
- The ministry provided additional funding of \$2 million to support programs for people with mental illness. These programs include: intensive community support for people with mental illness as an alternative to hospitalization; hiring additional community living support workers to assist individuals to regain practical

skills in areas of personal care and home management; and, a demonstration project to evaluate home-based treatment and emergency stabilization for adults with acute psychosis.

- The ministry invested an additional \$9.3 million for renewal and expansion of home care services across B.C. New services enhance access to community-based support and help to ease pressure on acute care beds.
- The ministry also launched a new B.C. Palliative Care Benefits Program, providing \$1.3 million to start and operate the program in 2000/2001. This program will support and enable individuals with an end-stage disease or illness to remain at home by providing medications, medical supplies and equipment at no charge.
- The ministry has committed funding to open 2,000 new residential continuing care beds between 2002 and 2005.
- \$160,000 was provided to establish a British Columbia Rural and Remote Health Institute at the University of Northern British Columbia. The new institute will help to build solutions for health care and service delivery in rural and remote regions of the province.
- Over \$12 million was allocated to introduce the BC HealthGuide program to assist British Columbians to access health information and advice. The program includes a medically-approved handbook, provided free to every household in B.C. It also provides access to a comprehensive Web site and nurse information line.

- An independent monitoring committee was established in December 2000 to report to the minister on the implementation and impact of the strategic investments. This committee is chaired by the Provincial Health Officer, Dr. Perry Kendall.

■ Physician Initiatives –

- The Ministry of Health continued to work with the British Columbia Medical Association to develop guidelines for effective and appropriate clinical practice. The ministry funds and supports the Guidelines and Protocols Initiative in partnership with the British Columbia Medical Association. Advisory committees involving over 80 doctors establish guidelines for effective practice. The committees provide recommendations to colleagues on diagnosis and treatment of common conditions, based on clinical evidence and consensus by B.C. doctors. In 2000/2001, the advisory committees developed four new medical guidelines. The following were approved and introduced: office and laboratory management of genital specimens; investigation of suspected infectious diarrhea; diagnosis and management of sore throat; and, use of homocysteine measurement in the evaluation of atherothrombotic disease. Other existing protocols were revised and updated during the year. Thirty-two protocols and guidelines have been adopted by the Medical Services Commission and are currently in effect covering a wide range of medical services.



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- The Ministry of Health and the British Columbia Medical Association reached a new Master Agreement – the primary agreement between physicians and the provincial government. The six-year agreement took effect April 1, 2001, and addresses issues such as consultation, establishment of advisory committees, restrictions on service withdrawals, and a process for dispute resolution. The Master Agreement establishes the framework for relations and subsequent negotiations between both parties.
- Negotiations began to renew the Working Agreement and several Subsidiary Agreements between the Ministry of Health and the British Columbia Medical Association. The Working Agreement is the financial agreement between the province and doctors. It includes fees and publicly-funded benefits such as continuing medical education, RRSP contributions, and disability and malpractice insurance. Subsidiary agreements cover issues of common interest among physicians, including those who are general practitioners or specialists, in rural practice, or on sessional, salary or service contract agreements. The ministry and the British Columbia Medical Association have agreed to refer all outstanding issues to binding arbitration.
- During the summer and fall of 2000, physicians across rural B.C. engaged in collective service withdrawals. As a result, the provincial government approved \$40 million in new funding to address these issues

through the Physician Recruitment and Retention Program. The rural physicians rejected this program and the issues were referred to a mediation panel. In December 2000, the Korbin Commission led an inquiry and released a report with recommendations on improving the contractual relationship between physicians and the province. A key recommendation in Korbin's report states that the provincial government, the B.C. Medical Association and doctors be bound to agreements negotiated and ratified on their behalf.

- **Alternative Payments Program** – During the fiscal year, 170 more physicians received all or part of their income through alternative funding arrangements outside of the usual fee-for-service method of payment from the Medical Services Plan. A total of 16 new service agreements or global funding contracts, plus 3,800 new sessions or units of 3.5 hours of service, have been funded across the province. Under the Alternative Payments Program, B.C. Cancer Agency's service agreement increased by \$5.6 million to deliver more services outside of major population centres.
- **Recruiting, Retaining and Educating Nurses and Doctors**
 - The ministry provided \$9.4 million for four new grant programs to reduce nursing shortages and improve working conditions for nurses in B.C.'s health care system. These grants support nurses in the workplace, help train and mentor nursing students and new nurses, and bolster recruitment and retention of nurses in rural communities.

- Other government measures to support the recruitment and retention of nurses in B.C. included 400 new nursing education seats and 50 refresher seats in post-secondary institutions, including refresher programs for foreign-trained nurses. Scholarships were also provided to help nurses upgrade their skills and encourage former nurses to return to nursing. New efforts were made to bolster the recruitment of nurses from outside B.C. Additional measures included new licensed practical nurse positions in the acute-care system and new education spaces for licensed practical nurses.

- In March 2001, the Provincial Nominee Program was launched to help recruit and retrain foreign-trained nurses in B.C. by facilitating the immigration process. About 65 nurses were identified as potential candidates for the program

- The Ministry of Health and the Faculty of Medicine at the University of British Columbia expanded the post-graduate residency program to recruit medical specialists in remote and rural areas of B.C. to replace their retiring peers. This initiative is coupled with increasing the enrolment of medical students. The faculty will admit eight new students in the fall of 2001, for a total annual enrolment of 128 students.

- **Health Human Resources** – In addition to addressing the nursing shortage, action was taken in other areas to ensure an adequate long-term supply of health care providers:

- Federal, provincial and territorial health ministers agreed to create a national health human resources strategy. The Advisory Committee on Health Human Resources is collaborating to address human resource issues across the Canadian health system. The committee is developing strategies for the recruitment, retention and placement of nurses and doctors. It is also conducting an environmental scan of 9 allied health professions. The subsequent report will provide a national overview of issues facing allied health professions and recommendations for action. The committee is also collecting baseline information on provincial entry and practice requirements for a range of health care providers.

- A Clinical Placement Database Project is under development in B.C. to improve opportunities for and coordination of clinical training for allied health students in post-secondary education programs.

- The Nursing Directorate was established to develop nursing policy and assist in strategic planning to support the ministry in achieving its mission and the provincial health goals. The directorate's priorities include assisting with nurse human resources, promoting supportive work environments for nurses, developing new models for practice and education, and promoting nursing as a career choice.

- A multi-stakeholder Nursing Advisory committee has been established to advise on the development, implementation



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and evaluation of nursing priorities, policies and strategies. Establishing a provincial committee fulfills one of the recommendations of the *National Nursing Strategy Report*.

- The B.C. Health Care Scholarship Fund allocation for 2000/2001 was \$1 million. An additional \$500,000 was allocated for the Nursing Education Bursary. Scholarships are awarded to help registered nurses, paramedical professionals and health support workers to upgrade their knowledge and skills. Medical laboratory technologists, medical radiation technologists, physical therapists and other health care professional can apply for bursaries.
- The Health as a Career Choice Forum brought health care providers, secondary school representatives and government together to develop strategies to improve the recruitment and retention of young people into all the health professions. A provincial Health as a Career Choice Working Group was established to build on the forum results.
- The Ministry of Health is leading the development and implementation of a new provider registry. The registry establishes standards for health care provider data for identifying each provider accurately, uniquely and consistently across the health care system. It also provides health care organizations with information to meet the operational and analytical needs of the health care industry. The registry provides data on the ministry, health authorities, service providers and the public.

This innovative project is being funded by the Canadian Health Information Partnership Program and the provinces of British Columbia, Alberta, Saskatchewan and Manitoba.

- Major collective agreements covering 100,000 health care employees in British Columbia expired on March 31, 2001, and during the last quarter of the fiscal year the Health Employers Association of B.C. was involved in contract talks with the unions representing these employees. Tentative agreements were reached with the communities sub-sector and the facilities sub-sector at the end of the fiscal year.

■ Pharmacare

- The provincial government amended a regulation under the *Pharmacists, Pharmacy Operations and Drug Scheduling Act* to improve access to emergency contraceptive pills (ECP) through direct distribution by licensed pharmacists. British Columbia is the first province to make ECPs available without a doctor's prescription, a policy announced in October 2000. Through the Pharmacare program, pharmacies receive an extra \$15 counselling fee for this service.
- Pharmacare extended stakeholder consultations with the Pharmaceutical and Therapeutics Committee of the British Columbia Medical Association. Pharmacare has also consulted and attended industry forums with drug manufacturers.

■ Surgical Wait List Registry -

The Web site and Surgical Wait List Registry was developed to inform patients and doctors of

wait times for specialists across the province, covering 20 categories of surgeries and treatments like cancer services, cardiac surgery and hip replacements. The registry includes data from about 1000 doctors at 47 of B.C.'s largest hospitals for 95 per cent of all scheduled surgeries in the province. The registry is monitored by a provincial wait list coordinator and managed by ministry staff.

■ **Progress on Mental Health Reform** – The provincial government continued to develop initiatives and take action on mental health reform:

- The Ministry of Health considers the full spectrum of mental health to address the treatment and support needs of people with mental illnesses. A key ministry initiative includes the provincial Mental Health Plan, which focuses on accessible and appropriate treatment and care. A Steering Committee with broad industry representation advises on implementing the provincial plan. There are also a number of task and work groups. The Mental Health Plan consists of annual projects for delivering measurable outcomes. The ministry's activities are guided by goals and objectives derived from evidence-based practice and research, stakeholder priorities, the Mental Health Plan, annual work plans, and performance and resource utilization reports.

■ In 2000/2001, the Ministry of Health supported the following key initiatives on Mental Health Reform:

- The Ministry of Health developed a set of accountability and planning

documents, *Foundations for Reform: The Mental Health Policy Framework and Key Planning Tools*, which provide policy direction to health authorities on mental health reform, outline the ministry's responsibilities, and provide planning tools for the health authorities. These documents were provided to health authorities and other stakeholders.

■ Strategic initiatives and resources provided to health authorities in 2000/2001 included:

- Funding to hire 54 acute diversion staff and rent differential for 275 units to offer alternatives to hospitalization for people with mental illness;
- Funding to hire community living support workers to support the community tenure of 77 people with serious mental illness living independently in the community; and
- Hosting two Acute Home Treatment Demonstration Projects to determine its suitability for rural and urban communities.
- A pilot project to provide treatment to people with both mental illness and concurrent substance misuse issues was initiated in the Central Vancouver Island Health Region.
- In collaboration with health authorities and other stakeholders, work was undertaken to advance best practices for special populations, including aboriginal peoples, women, the elderly and people with developmental disabilities.





FUNDING WAS
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- A project was initiated to develop a Framework of Practice for the Mental Health Workforce in partnership with the Ministry of Advanced Education, Training and Technology and post-secondary institutions. A series of self-assessment tools for individuals, health authorities and educational institutions will result.
- Community placements for 203 high need, hard-to-house individuals from Riverview and the Forensic Institute were facilitated through the Riverview Hospital/Forensic Psychiatric Institute Access Project.
- The ministry provided funding to three rural and remote hospitals, in addition to the eight initiated in the previous year, for staff training and renovations required for designation as Observation Units, under the *Mental Health Act*.
- A three-year pilot project was initiated to create linkages and develop strategies for more employment opportunities for people with mental illness. The Ministry of Health, Canadian Mental Health Association, the Ministry for Social Development and Economic Security and the Ministry of Advanced Education, Training and Technology participated in this pilot project.
- The Ministry of Health and other ministries formalized a process to identify issues, influence policy and plan services for integrated care and support for people with mental illness who have complex and multiple needs, including those involved in the criminal justice system and their families.
- The ministry developed integrated community linkages and strategies in each health region for the early identification and intervention of individuals demonstrating initial signs of mental illness. This province-wide project involved health authorities, the Ministry for Children and Families, the Ministry of Education, school districts and other stakeholders.
- **Provincial Trauma Program –** The Ministry of Health created a Provincial Trauma Strategy and a steering committee for the province. The strategy is intended to improve survival following injury and reduce preventable death rates. Six regional trauma centres have been established in communities across British Columbia, including Vancouver, Victoria, Kamloops, Kelowna and Prince George. In addition, provincial centres have been established at Vancouver General Hospital and B.C. Children's Hospital. This program will provide support, coordination and standardization of care for trauma patients through services offered at the centres.
- **Continuing Care Renewal –** The provincial government increased funding to enhance home care services and to provide more residential care beds in B.C. communities.
- In 2000/2001, the government allocated an additional \$9.3 million to enhance home care services. Health authorities received this initial investment in Continuing Care Renewal to adopt or develop new service

models to meet the needs of their communities. Enhanced home care services will provide support to individuals, enabling them to remain at home for as long as possible. These services may delay or prevent inappropriate admission to residential facilities and acute care hospitals, plus support early discharge from hospitals.

- The provincial government introduced a new B.C. Palliative Care Benefits Program on February 1, 2001, and allocated \$1.3 million in new funding for the remainder of the fiscal year. The program removes financial barriers and supports B.C. residents wishing to receive palliative care services and die at home, among family and friends. The new program gives B.C. families greater choice in receiving care in their communities by covering costs for medications, medical supplies and equipment. The program has two components. The Palliative Care Drug Plan covers the costs of approved drugs needed for care and treatment at home. Pharmacies are reimbursed through Pharmacare for the cost of drugs dispensed to qualified patients. Medical Supplies and Equipment Benefits covers the costs of supplies and equipment for qualified patients. Health authorities may consider several approaches in assisting qualified patients.
- As part of Continuing Care Renewal, the provincial government committed to open 2,000 new residential care beds, between 2002 and 2005. The number of beds in communities will vary according to local bed capacity and demand. New beds will

be integrated with other health-care services such as assisted living, day programs, home care, home support, primary care and outreach services. Under Continuing Care Renewal, the link to social housing, particularly housing for the elderly, will be strengthened. British Columbians requiring continuing care services will be able to live in their homes and communities for as long as possible.

PROMOTING GOOD HEALTH

- **Office of the Provincial Health Officer** – Dr. Perry Kendall is British Columbia's Provincial Health Officer. The role of the Provincial Health Officer includes advising on health issues, producing an annual report on the health of the population, and with the assistance of the Advisory Committee on Health Goals for British Columbia, reporting on progress toward the government's health goals.

The Provincial Health Officer released the following reports during the 2000/2001 fiscal year:

- *Provincial Health Officer's Annual Report 1999* – This was the first report to measure progress toward achievement of the health goals adopted by the province in 1998. These goals define the province's vision for a healthy population. The health goals also provide a framework for action for government, the private sector and the community at large to improve health and quality of life for British Columbians. Of the 93 health indicators presented, almost 42 or half showed an improving trend in the population's health. The report recommends





THE MINISTRY OF
HEALTH PROVIDES
ANNUAL INFLUENZA
IMMUNIZATIONS AT NO
COST TO INDIVIDUALS
AT HIGH RISK OF
CONTRACTING A
VIRUS TO VULNERABLE
POPULATIONS. THE
INFLUENZA STRATEGY
WAS EXPANDED IN
2000/2001 TO INCLUDE
EMERGENCY RESPONDERS
IN ADDITION TO HEALTH
CARE PROVIDERS

22 priority actions for government and specific actions that individuals, families, employers and municipalities can take to enhance their own and their communities' health.

- **Health Goals Regional Index** – This report ranks each region's relative performance in achieving British Columbia's health goals. Strengths and weaknesses of each region are noted. The index is based on indicators and data presented in the *Provincial Health Officer's Annual Report 1999*.
- **Antimicrobial Resistance: A Recommended Action Plan for British Columbia** – This report recommends priority actions to address the problem of drug resistance and to preserve the effectiveness of antibiotics. The *Action Plan* was developed in collaboration with an expert committee representing the areas of microbiology, infectious diseases, public health, medicine, veterinary medicine and the pharmaceutical industry.
- **Policy and Practice – A Report on the Use of British Columbia's Health Goals by B.C. Government Ministries** – This report assesses the province's use of health goals as a template for government planning. Results show that while the principles and concepts of health goals are evident in performance plans, the goals themselves have not yet been fully adopted or widely used to guide government policies and programs.

The above reports are available at no charge from the Office of the Provincial Health Officer or at <http://www.hlth.gov.bc.ca/pho/> on the Internet.

■ **Comprehensive Influenza Strategy** – The Ministry of Health provides annual influenza immunizations at no cost to individuals at high risk of contracting or transmitting the virus to vulnerable populations. The objectives of the strategy include: to decrease morbidity and mortality associated with influenza; to reduce the preventable, additional pressures on the health care system during the influenza season; and, to increase the capacity to distribute immunizations during the next influenza pandemic. The influenza strategy was expanded in 2000/2001 to include emergency responders in addition to health care providers. The high risk groups include seniors, as well as adults and children with chronic health conditions.

■ **Pneumococcal Immunization Expanded**

- For the third year, the ministry continued to offer pneumococcal vaccine to all persons 65 years and older to protect them against pneumococcal bacteria, which may cause pneumonia and serious illness among elderly people. Almost forty per cent of those eligible had received the vaccination by the end of the fiscal year, March 31, 1999.
- Beginning January 2001, the ministry expanded eligibility for the provincial immunization program to people ages 2-64 at high risk of contracting invasive pneumococcal disease.

■ **Enhanced Hepatitis Strategy –**

The Ministry of Health enhanced its Hepatitis Strategy. The strategy includes several components targeting various population groups:

- The ministry expanded its hepatitis B immunization program, effective March 2001. This includes an infant hepatitis B program, as well as targeting high-risk children and immigrant children under 12 years of age.
- The ministry expanded the hepatitis A immunization program. Several high-risk groups are eligible for free vaccine, including men who have sex with men, injection drug users, and hepatitis C-positive individuals.
- B.C.'s hepatitis strategy will also provide funding to improve coordination of care, case management and laboratory testing. This important strategy includes the appointment of a hepatitis secretariat in the future.

■ **Electronic Immunization**

Record System – The electronic immunization record system to increase child immunization levels continued to be implemented in seventeen of the eighteen health regions by the ministry.

■ **Public Health Information –**

The Ministry of Health continued to develop initiatives to improve access to public health information and services, promoting the well-being of British Columbians. The Public Health Information System tracks public health services offered in schools, homes and clinics. It also includes an immunization registry,

communicable disease data and client-tracking. The system allows for enhanced Provincial and Federal reporting requirements. It is designed to provide an efficient, cost-effective system to support the provincial mandates for service organizations and health care service providers.

- **BC HealthGuide** – An innovative addition to the health care system, the BC HealthGuide program was implemented across the province in spring 2001. All B.C. households received the BC HealthGuide Handbook, which provides information on over 190 common health concerns, home treatment options and prevention. It also provides advice on when to seek help from a health professional. Another component of the program is the 24-hour, toll-free BC HealthGuide NurseLine. It offers confidential health information and decision support on appropriate care, treatment options and health services. In addition, BC HealthGuide Online provides British Columbians practical health information and advice on over 2,500 health topics, tests and procedures.

■ **Cardiovascular Disease Prevention**

- The Ministry of Health has initiated the development of a comprehensive cardiovascular disease prevention strategy for B.C. During the 2000/2001 fiscal year, a draft document was distributed to stakeholders for consultation and a final report was prepared. The strategy and implementation will be revised in 2001/2002.

AN INNOVATIVE
ADDITION TO THE
HEALTH CARE SYSTEM,
THE BC HEALTHGUIDE
PROGRAM WAS
IMPLEMENTED ACROSS
THE PROVINCE



THE MINISTRY OF
HEALTH LAUNCHED
HONOURING OUR HEALTH:
AN ABORIGINAL TOBACCO
STRATEGY FOR BRITISH
COLUMBIA – THE FIRST
OF ITS KIND IN CANADA.
DESIGNED IN
COLLABORATION WITH
ABORIGINAL PEOPLE, THIS
COMMUNITY-BASED
INITIATIVE IS AN
INTEGRAL PART OF
THE PROVINCIAL
TOBACCO STRATEGY.

The strategy will establish a framework to guide prevention activities, build consensus among stakeholders and stimulate actions to decrease the incidence of cardiovascular disease among British Columbians. The strategy will also play a critical role in chronic disease prevention and the overall promotion of health.

- The dissemination phase of the British Columbia Heart Health Project is a five-year research project jointly funded by the Ministry of Health and Health Canada. This project supports and evaluates the implementation of effective cardiovascular prevention programs by health authorities.

- **Diabetes Prevention and Control** – The Ministry of Health is developing a diabetes strategy for B.C. The strategy will address all aspects of prevention and engage health care partners in promoting a long-term, coordinated effort to reduce the impact of diabetes. In 2000-2001, the ministry and Health Canada formed the B.C. Diabetes Reference Group to assist with developing and implementing the Canadian Diabetes Strategy. The ministry will also work with health authorities who operate 85 diabetes education centres, hospitals, continuing care facilities and public health programs across the province.

- **Tobacco Strategy** – Several steps were taken to prevent tobacco use and to strengthen tobacco reduction efforts in British Columbia:

- The provincial government amended B.C.'s tobacco legislation to continue its legal action against tobacco companies to recover health care costs associated with smoking.
- In January 2001, the Ministry of Health launched *Honouring Our Health: An Aboriginal Tobacco Strategy for British Columbia* – the first of its kind in Canada. Designed in collaboration with Aboriginal people, this community-based initiative is an integral part of the provincial Tobacco Strategy. The Aboriginal Tobacco Strategy's priorities include: mobilizing Aboriginal leadership; supporting the larger vision of cultural re-vitalization; generating community participation and service; developing community capacity; strengthening relationships with health authorities; integrating the strategy with existing health and social initiatives; implementing best practices in reducing misuse of commercial tobacco while respecting traditional uses of tobacco in Aboriginal communities; and, evaluating progress.
- In January 2001, the ministry marked National Non-Smoking Week with the release of the second edition of *Gasp* magazine – a magazine for teens that depicts the dangers of smoking by using graphic images, personal stories and facts about tobacco use.

- To reduce tobacco use among youth, the ministry hosted Canada's first anti-tobacco youth summit. Eighty young people from across the province attended the Kids Against Tobacco Summit – KATS – in February 2001. Youth participated in dynamic and interactive workshops aimed at inspiring them to develop local anti-tobacco initiatives in their own communities.

■ **Radiation Protection** – Skin cancer rates have more than doubled over the past twenty years. The Ministry has developed a *Sun Awareness and Skin Cancer Prevention Strategy* and established a Provincial Advisory Committee for B.C. New funding of \$150,000 was provided to support prevention and awareness initiatives. Examples included Sun Smart public awareness events in 50 locations across the province and Sun Awareness messages broadcast on community television stations.

■ **Health Care for People with Disabilities**

- Health Services for Community Living is a comprehensive program for persons with developmental disabilities. The Ministry of Health provides policy direction, standards, guidelines and advice on nursing, medical care and rehabilitation to health authorities and health professionals within Continuing Care. Services provided in the regions include nursing, physical therapy, occupational therapy, dental hygiene, nutrition and specialized dysphagia.

- In 2000, the Ministry of Health contracted with the British Columbia Association for Community Living to develop and present a community education program on access to health care for people with developmental disabilities. The impetus for this program was a report addressing the need for equitable access and advocacy, prepared for the provincial government. Seminars were presented by the Office of the Public Guardian and Trustee, the Langley Association for Community Living and the ministry.

- The Ministry of Health provided an additional \$236,000 to enhance assessment and diagnostic services at Sunny Hill Health Centre for Children to reduce the waiting list for children with query autism spectrum disorder. This disorder refers to a spectrum of pervasive developmental disorders, which present lifelong disability for individuals.

■ **Drinking Water Quality** – The provincial government took action to enhance the protection of drinking water in British Columbia:

- The Ministry of Health participated in public consultations and information sessions on a proposed drinking water protection plan for British Columbia, primarily organized by the Ministry of Environment, Lands and Parks. The public and stakeholders across the province provided recommendations and feedback on the development of a new source-to-tap *Drinking Water Protection Act* under the Ministry of Health.





A PHYSICIAN
RECRUITMENT AND
RETENTION PROGRAM
WAS CREATED TO
ADDRESS WORKLOAD
AND PRACTICE ISSUES
OF DOCTORS WORKING
IN RURAL AND
REMOTE AREAS OF B.C.

- The government is in the process of amending the Safe Drinking Water Regulation, originally brought into force in 1992, to enhance the protection of public health and drinking water in B.C. The amendments add new water quality and treatment standards. They also require purveyors to monitor drinking water quality and to report results to the public. Medical Health Officers and Environmental Health Officers also have more guidelines and authority to ensure compliance and provision of safe drinking water in their regions and communities.

■ HIV/AIDS Prevention –

In 2000/2001, the Ministry of Health provided over \$11 million in funding for community HIV/AIDS programs and services in British Columbia – the highest per capita funding in Canada.

- The ministry continued to purchase and distribute needles, syringes, condoms and lubrication to needle exchanges across the province. These have been essential cost-effective interventions.
- The ministry continued to provide guidelines and requirements to health authorities for developing regional HIV/AIDS plans.
- The HIV/AIDS Advisory Committee provides policy advice and reports to the Minister of Health. The committee published its 1999/2000 Annual Report.

- The Inter-Ministry Committee on HIV/AIDS released its report entitled *Action on HIV/AIDS*. This report outlines work requiring inter-ministerial leadership and coordination.
- Information on HIV/AIDS prevention is now available on the ministry's Web site: <http://www.hlth.gov.bc.ca/hiv/>

■ Recorded Health Files –

The Recorded Health Files Program was launched in May 2000. The Health Files are a series of over 120 fact sheets on a wide range of public and environmental health and safety issues, widely used by public and preventive health workers throughout the province. This new program allows British Columbians to call toll-free in the province or locally in Greater Vancouver to listen to any or all of the Health Files. This new program was developed to enable people across the province to access these fact sheets, including those living in remote communities or having low literacy skills.

ENHANCING REMOTE AND RURAL HEALTH CARE

- The Ministry of Health initiated a Physician Recruitment and Retention Program to address workload and practice issues of doctors working in rural and remote areas of B.C. The ministry collaborated with health authorities, developed guidelines and established a committee for implementation. Changes were made to the Physician Recruitment and Retention Program as a result of the Hope Mediation in November 2000. These

included developing a new payment program for rural physicians.

- Through the Northern and Isolation Travel Assistance Outreach Program, funding was provided for an estimated 1728 visits by family doctors and specialists to 61 rural communities, paying for a travel time honorarium, travel expenses and accommodation costs.
- The Northern and Rural Locum Program assisted physicians practicing in small communities to secure subsidized Continuing Medical Education and vacation relief. The program supported 2,622 locum days in 240 assignments to relieve 92 physicians in 48 communities. The program won a Public Service Bronze Award for excellence.
- Health Match BC facilitated the hiring of 99 doctors in rural and remote communities in B.C. Specifically, 41 doctors were employed in permanent positions, 30 doctors accepted offers of employment for permanent positions, and 28 doctors were placed in locum positions. Health Match BC also helped to hire 65 registered nurses in rural and urban centres. Thirty-two nurses were employed in permanent positions, and 10 nurses accepted offers for permanent positions. Health Match BC has also assisted health care employers with their recruitment process.

IMPROVING ACCESS TO HEALTH CARE FOR POPULATIONS AT RISK OF POOR HEALTH

- **Supporting Seniors** – B.C.'s Senior Citizen Counsellor Program is administered by the ministry's Office for Seniors. Located throughout the province, 150 volunteer counsellors answer more than 6,000 requests per month from seniors who need assistance with health, housing, transportation, elder abuse or financial issues.
- **Community Care Facilities** – The ministry continues to refine regulations to promote the health and safety of children, youth and adults cared for in licensed community care facilities. A comprehensive review of existing residential care requirements is currently underway.
- **Women's Health** – Workshops to promote awareness of and action on women's health issues were conducted in 12 regions throughout B.C. Workshop topics included: health issues for Aboriginal women; gender inclusive analysis; medicalization of women's health; violence against women; women and mental health; and, women and substance misuse.
- **Aboriginal Health**
 - In January 2001, the Ministry of Health released Canada's first Aboriginal Tobacco Reduction Strategy - Honouring Our Health. A total of \$428,000 was allocated for 2000/2001 for community-based cessation, prevention and training activities. The first year of the strategy aimed to build community capacity to implement effective tobacco





reduction activities through regional training, distributing resources and developing networks with local health authorities.

- In partnership with the First Nation Chiefs' Health Committee, the ministry's Aboriginal Health Branch presented a series of information sessions in 10 communities across B.C. These sessions offered Aboriginal peoples information on provincial health services and health authorities, and provided an opportunity for discussion on improving services to First Nations communities. More than 300 people participated in the sessions, which took place between January and April 2001.
- The third annual Aboriginal Governors' Forum was held in March 2001 in Vancouver, B.C. The Ministry of Health reported on progress in implementing the 50 recommendations put forward by the Aboriginal Governors' Working Group, and the intent of the ministry to require all health authorities to develop Aboriginal health service plans for their communities.
- The Aboriginal Health Branch sponsored the fourth annual Healing Our Spirit BC First Nations AIDS Society Conference - Building on the Strengths of Aboriginal Communities - held in Prince Rupert in March 2001. The branch also sponsored annual Aboriginal AIDS Awareness Day activities held in conjunction with World AIDS Day, December 1, 2000.
- The Ministry of Health continues to participate in the federal/provincial/territorial Aboriginal Working Group on HIV/AIDS. Staff of the Aboriginal Health Branch also participate in and co-chair the Western Aboriginal Health Officials Working Group. The group identifies opportunities, principles and strategies for working together with the federal government on Aboriginal health issues.
- The branch provided new funding of \$580,000 to implement strategic initiatives. These included encouraging Aboriginal people to choose health careers through bursaries, developing prevention strategies for hepatitis C, and supporting urban Aboriginal health care centers in delivering primary care.

ESTABLISHING A STRONG AND EFFECTIVE GOVERNANCE AND DELIVERY SYSTEM

■ Monitoring Health Authority Accountability and Performance

- Health service plans are three-year, rolling strategic plans outlining service delivery by health authorities across B.C. These plans outline expectations of both the ministry and health authorities in providing health care services. In 2000/2001, Community Health Councils and Community Health Service Societies submitted their first health service plans to the Ministry of Health for review and approval. Regional Health Boards submitted their second health service plans.

- The ministry has completed and distributed its initial *Health Authority Performance Indicators Report* to local health authorities as a draft for consultation. This report tracks high-level performance indicators that demonstrate how the health system is functioning. It is also an accountability tool to help the ministry understand how well health authorities are meeting B.C.'s strategic health goals and objectives.
 - The ministry is reviewing the reporting relationship and accountability framework that exists with the health authorities. As a result, changes will likely be made to the ministry's planning and reporting requirements for health authorities.
- **Health Authority Board Members** – The Appointment Guide for Health Authorities provides guidelines for the appointment process to ensure board members reflect the diversity of their communities and possess the required skills and abilities.
- **Informed Consent** – In accordance with a recommendation by the Krever Commission, the ministry directed hospitals to develop and implement an informed consent procedure for administering blood and blood products to patients. The Provincial Blood Coordinating Office operates the Central Transfusion Registry, which tracks the disposition of blood and blood products. The office coordinated the development of guidelines and informational materials for physicians and patients, which were distributed to hospitals.

Two thirds of hospitals have implemented or are in the process of implementing an informed consent process.

REJUVENATING THE HEALTH CARE SYSTEM FOR LONG-TERM SUSTAINABILITY

■ Innovations in Health Care Management –

The ministry's Information Management Group has developed several information systems to assist health care providers and administrators in the delivery of services.

- Thirty hospital emergency departments have connected to the PharmaNet system, providing access to patient profiles to assist in diagnosis and treatment. Eighty-five physician offices have also participated in a pilot program to connect to this system. The pilot program is being evaluated to determine its usefulness for physicians.
- In addition, the Information Management Group has developed a Web-based interface to the Medical Services Plan, which allows employers to determine eligibility for benefits. The new system improves efficiency and service.
- The ministry has provided leadership in developing standards and applications that will support the federal/provincial/territorial initiatives to create an electronic health record. It has developed a provincial standard for electronic laboratory test ordering and results delivery that has been adopted by three other western provinces in Canada.

THE INFORMATION
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HAS DEVELOPED
SEVERAL INFORMATION
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HEALTH CARE
PROVIDERS AND
ADMINISTRATORS
IN THE DELIVERY
OF SERVICES



THE BRITISH COLUMBIA
VITAL STATISTICS
AGENCY WAS AWARDED
A SILVER MEDAL FOR
ITS INNOVATIVE AND
COST-SAVING VISION
SOFTWARE AT THE
NATIONAL DISTINCTION
AWARDS 2000,
SPONSORED BY
CANADIAN INDUSTRY
LEADERS TO RECOGNIZE
EXCELLENCE IN
INFORMATION
MANAGEMENT AND
TECHNOLOGY IN THE
PUBLIC SECTOR.

- The ministry is also leading the development of an E-claims standard with the participation of other provinces and the Canadian Institute for Health Information. The new standard enables health care providers to electronically bill for payments for services delivered.
- The ministry's Information Management Group has developed a comprehensive Health Data Warehouse for use by health system planners, researchers, administrators and governors.
- The Ministry of Health has also developed the Application, Assessment and Classification Project with pilot projects being implemented from 2000/2001 to 2005. This project responds to recommendations in the Continuing Care Community for Life Report and the mandate for Continuing Care Renewal. This new application, assessment and classification system for health services provides clients and caregivers access to information for making informed choices. The system improves the quality and consistency of information used for evidence-based decision making by practitioners, administrators, health authorities and the Ministry of Health. In addition, the system provides common access to eligibility criteria for clients to continuing care and home support services such as palliative care, home care, post-acute care and mental health services.

■ Innovative Technologies

- The British Columbia Vital Statistics Agency was awarded a silver medal for its innovative and cost-saving Vision software at the national Distinction Awards 2000, sponsored by Canadian industry leaders to recognize excellence in information management and technology in the public sector. Vision software is a vital event processing and certification system. It organizes data from birth, marriage and death registrations, performs data quality checks, processes applications, and prints certificates and licences. Since its implementation in 1998, Vision software has reduced errors, processing time and annual costs at the agency. Recognized by many as leading technology in the vital statistics field, Vision software is currently licenced for use in four American states. Using new Web technologies, Vision will expand online services to hospitals, funeral homes, civil marriage commissioners, marriage licence issuers, other service providers and the public.
- The British Columbia Vital Statistics Agency maintains a Health Status Registry of B.C. residents less than 20 years of age with selected long-term disabilities and individuals of any age with genetic conditions. The agency continues efforts to improve and expand reporting from sources, including the health regions, B.C. Children's Hospital, the University of British Columbia, and Victoria General Hospital's Medical Genetics department. The Health Status Registry provides a tool that can be

used for planning and development of health services, research and analysis of congenital anomalies and handicapping conditions, and ongoing surveillance of the incidence and prevalence of these conditions in the B.C. population.

- The need for accurate health statistics and population estimates for British Columbia's Status Indian Population is acute. Consistent and reliable data are essential to monitor health status, to assess health needs, and to plan, fund and deliver health care to the province's Status Aboriginal peoples. The British Columbia Vital Statistics Agency has developed provincial and regional Status Indian population estimates based on current and historical B.C. Medical Services Plan and Vital Statistics administrative files. Accurate population estimates are necessary to derive measures of health status indicators. Identification of membership in the Status Indian population for vital events in B.C. are determined by record linkage between data obtained from Vital Statistics, the B.C. Medical Services Plan and the Indian Status Verification file from the First Nations and Inuit Health Branch, Health Canada.
- The British Columbia Vital Statistics Agency is nearing completion of the development of a Vital Event warehouse (VISTA). The database will provide better access to birth, death and marriage statistics to support the information needs of agency clients and partners. The system will allow assessment of provincial and regional

mortality and natality health issues by generating measures of health status. The system will apply statistical tests for time trends and regional comparisons. It will also identify potential health issues and conduct surveillance of current mortality and natality population health indicators.

■ Primary Care

- The Ministry of Health has developed an enhanced model for the delivery of primary care in B.C. communities. The Primary Care Division is actively promoting this model of care with health authorities and health service providers. The model establishes primary care centres to provide integrated health services, 24-hours a day and seven days a week, by a multidisciplinary team of health professionals. The ministry has also developed and implemented a population-based model for funding primary care centres.
- The ministry provided funding for eight Primary Care Demonstration Projects in B.C. communities. The ministry allocated funding for medical services and health professionals at new primary care centres. The federal government provided project start-up costs.
- In December 2000, increased funding of \$2.5 million for additional primary care projects was announced for the 2001/2002 fiscal year. Annual funding of \$2.5 million will be provided for primary care over four years. Seven new sites have been confirmed for the 2001/2002 fiscal year.

THE MINISTRY OF
HEALTH HAS DEVELOPED
AN ENHANCED MODEL
FOR THE DELIVERY OF
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TO PROVIDE INTEGRATED
HEALTH SERVICES,
24 HOURS A DAY AND
SEVEN DAYS A WEEK, BY
A MULTIDISCIPLINARY
TEAM OF HEALTH
PROFESSIONALS.



■ **Traditional Chinese Medicine –**

The provincial government announced that B.C. would regulate traditional Chinese medicine therapies, based on recommendations made by the Health Professions Council. In December 2000, British Columbia became the first province to regulate the full range of traditional Chinese medicine therapies under the College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia.

■ **New and Emerging Treatments –**

The ministry supported and expanded innovative treatments in several areas of health care:

- The Ministry of Health has targeted funding for the Progressive Renal Insufficiency Program, designed to reduce the progression of renal disease for patients with impaired kidney function and to prepare patients for renal replacement therapies, including dialysis and transplants. The purpose of the program is to coordinate and streamline care, educate patients and their families, and reduce the amount of resources required for emergency treatment.
- The ministry continued to fund brachytherapy treatment for men whose cancer is localized in the prostate gland. Brachytherapy is a relatively new form of radiotherapy that implants radioactive seeds into the prostate. Treatment is completed in one visit and there are fewer side effects.

- Funding of \$100,000 was provided for the treatment of patients using deep brain stimulation technology for Parkinson's disease, multiple sclerosis and other movement disorders.

■ **Health Capital Projects –**

A wide range of capital projects were funded to provide new and improved health care facilities for British Columbians. Major projects undertaken by the Ministry of Health in the 2000/2001 fiscal year included:

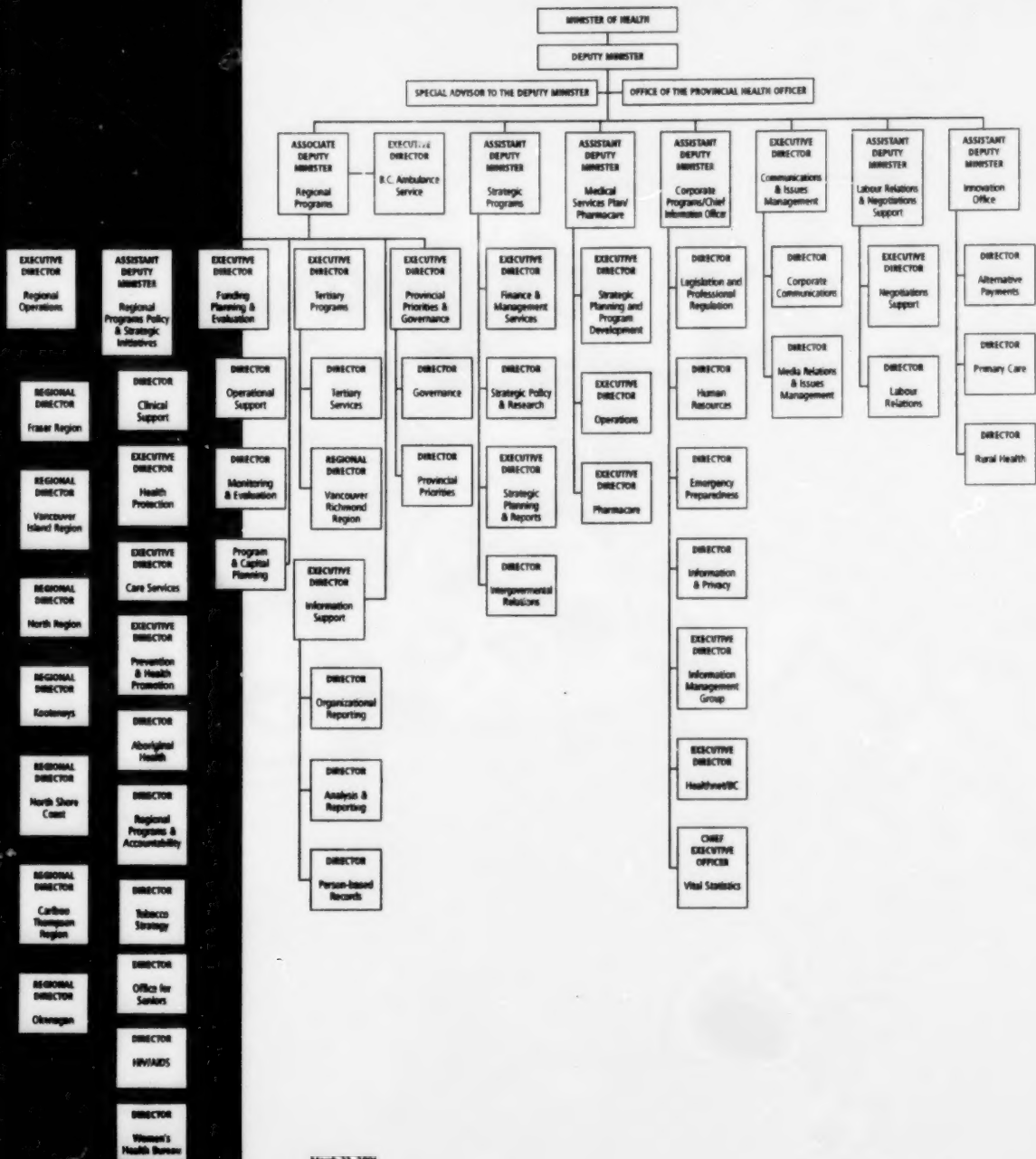
- The B.C. Cancer Agency's new Vancouver Island Cancer Centre opened in March 2001. The new centre provides cancer care and treatment to people residing on Vancouver Island and the Gulf Islands. The Ministry of Health contributed \$39.3 million of the \$46-million project to build and equip the new centre. The ministry also provided \$1.9 million in start-up costs and \$400,000 in one-time operational funding to enable the centre to open early, upon completion of construction. The new centre adds 20 per cent more treatment capacity for Island residents and reduces service pressures in other cancer centres in the province.

- A new wing and children's health centre opened at Surrey Memorial Hospital. The new wing increases the number of operating rooms, in-patient beds and special-care bassinets in the nursery. The children's health centre includes an adolescent psychiatric inpatient unit, a family birthing unit and a neonatal intensive care unit. More parking spaces have been added for patients and visiting families. The Ministry of Health provided total funding of \$76.5 million required to complete the hospital addition.
- The new Ambulatory Care Building at B.C. Children's Hospital has been under construction during the 2000/2001 fiscal year. The new unit is designed to meet the increasing demand for clinic and day surgery services. The five-story building will provide more patient and family amenities such as breastfeeding rooms, quiet rooms, change rooms and expanded waiting rooms with play areas.
- Construction began to expand and redevelop the Prince George Regional Hospital. This project includes building a four-story medical surgical tower, adding more out-patient services, expanding the hemodialysis and pediatric units, and upgrading the emergency department. The ministry approved \$50 million in funding for phase one of the project.
- \$1 million in funding was approved for a new specialized mental health facility on the grounds of Prince George Regional Hospital. The 10-bed facility will help house and care for people with serious or persistent mental illness, providing assessment, treatment and rehabilitation.
- Funding of \$10.98 million was approved to enlarge the new diagnostic and treatment center being built at Royal Jubilee Hospital in Victoria. The new plan for the centre will add a fifth floor to house a laboratory and up to 16 intensive-care beds. The plan also allows for future cardiac-care expansion.
- Funding of \$7.82-million was approved for a kidney dialysis centre to be built on the Royal Jubilee Hospital site. The new centre will increase services for the region from 19 to 30 stations, with enough space to expand to 60 stations to meet future demand.
- New funding of \$10 million was approved for Phase 2 of the Nanaimo Regional General Hospital redevelopment project. This funding will expand and upgrade the operating rooms, plus develop a contemporary nursery and maternity area.
- Work began at Trail Regional Hospital to expand ambulatory care facilities. The \$6.7-million unit will enable the hospital to deliver a wide range of outpatient services, including surgical day care, a surgical suite and an expanded emergency area.

- Work began on the \$3.5-million renovation and expansion project at the Golden and District General Hospital. Improvements to the hospital will include expanding and redeveloping emergency and main entry areas, as well as major mechanical and electrical upgrades.
- Eagle Ridge Manor, a new multi-level-care addition to the Port Hardy Hospital, opened in July 2000. The ministry provided \$1.5 million for the construction of the 10-bed unit and a multi-purpose room, as well as renovations for the hospital's labour and delivery room. The manor will provide 24-hour care to residents in a home-like setting.
- Construction started on the new \$5.6-million Cormorant Island Health Centre that will replace St. George's Hospital in Alert Bay. The centre will provide acute care and multi-level-care beds, diagnostic and treatment facilities, community health programs and support services.
- New funding of \$5.32 million was approved for completing construction of the Clearwater Health Care Centre. The centre will integrate health-care services including a diagnostic imaging centre, six acute-care beds, one respite bed, a birthing room, 20 multi-level-care beds and more space for public health programs. Site development also includes a new B.C. Ambulance station.

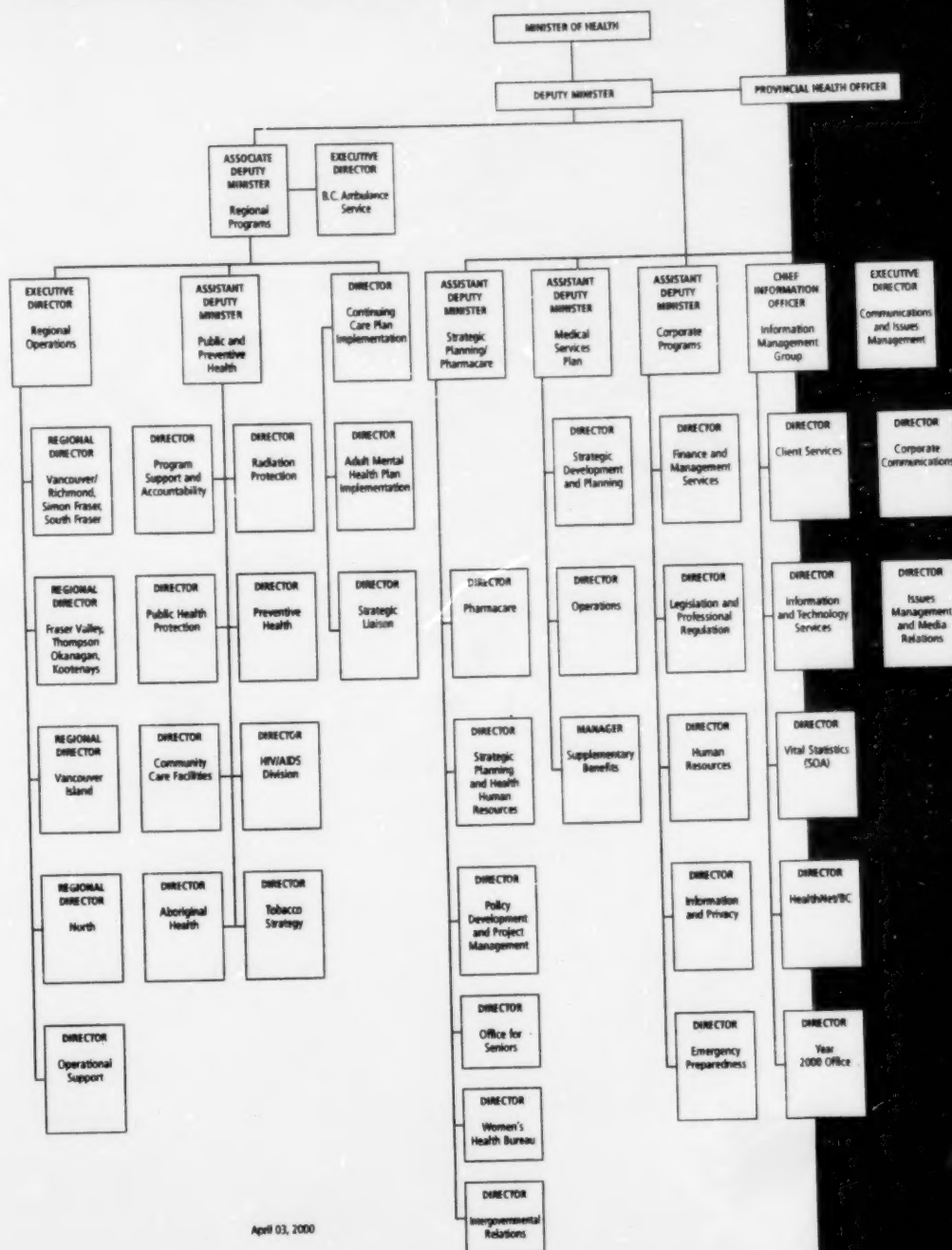


APPENDIX 1 – MINISTRY ORGANIZATIONAL CHART FOR MARCH 2001



March 22, 2001

APPENDIX 1 – MINISTRY ORGANIZATIONAL CHART FOR APRIL 2000



APPENDIX 2 – ACTS AND PROFESSIONS UNDER THE JURISDICTION OF THE MINISTER OF HEALTH AND MINISTER RESPONSIBLE FOR SENIORS

ACTS

Access to Abortion Services Act
Anatomy Act
Chiropractors Act
Community Care Facility Act
Continuing Care Act
Dentists Act
Forensic Psychiatry Act
Health Act
Health Authorities Act
*Health Care (Consent) and
Care Facility (Admission) Act*
Health Emergency Act
Health Professions Act
Health Research Foundation Act
Health Special Account Act
Hearing Aid Act
Hospital Act
Hospital District Act
Hospital Insurance Act
Human Tissue Gift Act
Marriage Act
Meat Inspection Act
Medical Practitioners Act
Medicare Protection Act
Mental Health Act
*Milk Industry Act (Section 12,
except in respect of tank milk
receiver licences)*
Ministry of Health Act
Name Act
Nurses (Registered) Act
Optometrists Act
*Pharmacists, Pharmacy Operations and
Drug Scheduling Act (except Part 8)*
Podiatrists Act

Public Toilets Act
Seniors Advisory Council Act
*Tobacco Damages and Health Care
Costs Recovery Act*
Tobacco Fee Act [not in force]
Tobacco Sales Act
Venereal Disease Act
Vital Statistics Act
Wills Act (Part 2)

PROFESSIONS

*Traditional Chinese Medicine
Practitioners and Acupuncturists*
Chiropractors
Dental Hygienists
Dental Technicians
Dentists
Denturists
Emergency Medical Assistants
*Hearing Aid Dealers (including
audiologists in private practice)*
Licensed Practical Nurses
Massage Therapists
Medical Practitioners
Midwives
Naturopaths
Occupational Therapists
Opticians
Optometrists
Pharmacists
Physical Therapists
Podiatrists
Psychologists
Registered Nurses
Registered Psychiatric Nurses

APPENDIX 3 – 2000 LEGISLATIVE CHANGES

Two Acts administered by the ministry were amended or enacted during the 2000 Sitting of the Legislative Assembly:

TOBACCO DAMAGES AND HEALTH CARE COSTS RECOVERY ACT (BILL 15)

- This Bill repealed and re-enacted the *Tobacco Damages and Health Care Costs Recovery Act*. This Act was found to be unconstitutional by the Supreme Court of British Columbia due to extraterritorial provisions beyond the province's jurisdiction. The re-enacted *Tobacco Damages and Health Care Costs Recovery Act* no longer contains the extraterritorial provisions. The Act was brought into force in January 2001, allowing B.C. to resume its legal action against the tobacco industry to recover health-care costs.

MISCELLANEOUS STATUTES AMENDMENT ACT (NO. 2), 2000 (BILL 24)

- The *Dentists Act* was amended to enable the making of regulations regarding the retention of dental records by dentists. This resulted from an amendment to the *Limitation Act* that reduced the period of time within which actions may be brought against dentists from 30 to 10 years.

APPENDIX 4 – REPORT ON RESOURCES

A: BUDGETED VERSUS ACTUAL EXPENDITURES BY MAJOR PROGRAM AREA (THOUSANDS OF DOLLARS)

MINISTRY OF HEALTH – 2000/2001

BUDGETED VERSUS ACTUAL EXPENDITURES BY MAJOR PROGRAM AREA

	2000/2001 BUDGET NOTE 1	2000/2001 ACTUALS (UNAUDITED) NOTE 2	DIFFERENCE
Regional Programs:			
Adult Mental Health	\$370,294,596	\$363,818,895	\$6,475,701
Public and Preventive Health	\$207,063,353	\$204,202,671	\$2,860,682
Acute and Continuing Care	\$4,890,230,987	\$4,772,042,388	\$118,188,599
	\$5,467,588,936	\$5,340,063,954	\$127,524,982
Emergency Health	\$155,017,665	\$163,930,413	(\$8,912,748)
Medical Services Plan	\$2,111,301,710	\$2,118,292,935	(\$6,991,225)
Pharmacare	\$660,774,400	\$656,865,249	\$3,909,151
Corporate Services:			
Information Management Group	\$58,921,151	\$63,864,536	(\$4,943,385)
Corporate Programs	\$8,346,635	\$8,621,839	(\$275,204)
Strategic Programs	\$41,443,503	\$39,054,380	\$2,389,123
Other Corporate Services	\$3,603,000	\$3,830,768	(\$227,768)
	\$112,314,289	\$115,371,523	(\$3,057,234)
Other	\$264,120,135	\$259,463,354	\$4,656,781
Total	\$8,771,117,135	\$8,653,987,428	\$117,129,707

NOTES:

- 1) Budget includes all appropriations: 2000/2001 Estimates, Supplementary Estimates and other statutory appropriations, per draft public accounts. Figures are unaudited.
- 2) 2000/2001 actual expenditures per draft public accounts are unaudited.
- 3) Regional Programs underexpenditure due to change in government's classification of some expenditures as capital in nature (primarily grants for clinical equipment).
- 4) Emergency Health overexpenditure due to impact of job action, new collective agreement and WCB costs.
- 5) MSP overexpenditure primarily due to physician service contracts.
- 6) Pharmacare program is demand-driven, savings accrued in several plans.
- 7) Overexpenditure in Corporate Services due to write-down of capital asset, net of operational savings. Other Corporate Services includes Communications and Labour Relations/Negotiations Support.
- 8) Other includes: Amortization of Prepaid Capital Advances, Debt Service Contributions, Vital Statistics, Minister's office and Special Accounts. Surplus due to stronger than expected sinking fund earnings.

B: ACTUAL VERSUS ESTIMATED NUMBER OF FTE's IN 2000/2001

MINISTRY OF HEALTH FTE SUMMARY BY PROGRAM FOR 2000/2001

	2000/2001 FTE BUDGET	2000/01 FTE ACTUALS	DIFFERENCE
Regional Programs:			
Adult Mental Health	25.00	17.15	7.85
Public and Preventive Health	152.26	136.80	15.46
Acute and Continuing Care	124.90	108.44	16.46
	302.16	262.39	39.77
Emergency Health	1,693.00	1,754.97	(61.97)
Medical Services Plan	424.00	381.17	42.83
Pharmacare	86.78	79.70	7.08
Information Management Group	202.50	166.28	36.22
Corporate Programs	106.05	93.37	12.68
Strategic Programs	327.97	275.99	51.98
Other Programs	42.54	29.37	13.17
Total	3,185.00	3,043.24	141.76

NOTES:

- 1) Emergency Health Services overutilization due to new positions implemented during the year to address workload. 79 new FTEs were provided in the 2001/2002 budget for these positions.
- 2) Other Programs include Minister's Office, Communications, Labour Relations and Negotiations Support.
- 3) Ministry figures exclude Vital Statistics. Underutilization reflects recruitment lag over the entire year. FTE utilization at year end was significantly higher (3,158 FTEs utilized in March 2001)

C: ACTUAL VERSUS ESTIMATED GROSS REVENUES FOR 2000/2001

	2000/2001 ESTIMATED REVENUES	ACTUALS REVENUES
Medical Services Plan	\$ 890,560,000	\$ 895,601,000
BC Ambulance Services	\$ 23,220,000	\$ 22,195,000
Vital Statistics Agency	\$ 10,069,000	\$ 9,995,000
Other	\$ 34,857,000	\$ 40,078,000
Total	\$ 958,706,000	\$ 967,869,000

NOTE: 'Other' includes \$16.5M for Hepatitis C.

D: REVENUES AND ACCOUNTS RECEIVABLE PROGRAMS

MEDICAL SERVICES PLAN (MSP) Collection of Overdue MSP Premiums Receivable

FISCAL YEAR	TOTAL REVENUE	COLLECTIONS NOTICES	COLLECTIONS AND CREDIT ADJUSTMENTS *
2000/2001	\$895,601,000	\$41,349,948	\$64,095,630 ¹
1999/2000	868,263,000	48,760,327	82,900,912
1998/1999	876,047,000	60,495,000	44,242,000
1997/1998	881,826,000	54,384,000	33,652,000
1996/1997	853,262,000	35,338,000	15,450,000

Aging of MSP Premiums Receivable

FISCAL YEAR	TOTAL	CURRENT	30-60 DAYS	60-90 DAYS	OVER 90 DAYS
March 31, 2001	\$101,978,114 ^{2,3}	\$29,344,594	\$9,651,327	\$3,428,428	\$59,583,765
March 31, 2000	83,159,816 ³	27,728,253	7,045,567	3,482,546	44,903,450
March 31, 1999	75,680,927 ³	12,161,511	7,454,562	2,725,694	53,339,160
March 31, 1998	54,246,519 ³	13,015,195	9,187,698	1,679,532	30,364,094
March 31, 1997	25,402,857 ³	7,921,582	4,237,681	1,089,114	12,154,480

MSP Premiums Receivable - Turnover and Days Billings Uncollected
Accounts receivable turnover is one indication of the timeliness of collection. Accounts receivable turnover for MSP Premiums Receivable was 8.78 times for fiscal 2000/01, 10.4 times for fiscal 1999/00, 11.6 times for fiscal 1998/99.
Days Billings Uncollected is another indication of the speed of collecting accounts receivable. 2000/01 - 42 days; 1999/00 - 35 days; 1998/99 - 32 days.
*Collections and Credit Adjustments include premiums paid, and adjustments that reduce indebtedness.

BC AMBULANCE SERVICES Collection of Overdue Ambulance Service Fees

FISCAL YEAR	TOTAL REVENUE	COLLECTION NOTICES	COLLECTION AND CREDIT ADJUSTMENTS **
2000/2001	\$22,195,281	\$11,712,737	\$6,043,494
1999/2000	24,372,818	10,272,287	6,211,295 ¹
1998/1999	23,496,000	13,349,000	7,347,000
1997/1998	22,445,000	9,542,000	4,818,000
1996/1997	18,706,000	7,831,000	4,583,000

Aging of Ambulance Fees Receivable

FISCAL YEAR	TOTAL	CURRENT	30-60 DAYS	60-90 DAYS	OVER 90 DAYS
March 31, 2001	\$22,346,391 ⁴	\$10,387,579 ⁴	\$855,755	\$327,171	\$10,775,886
March 31, 2000	11,047,934	1,796,950	913,085	386,409	7,951,490
March 31, 1999	9,488,913	1,265,355	408,006	308,543	7,507,009
March 31, 1998	10,344,927	2,575,413	954,471	380,966	6,434,077
March 31, 1997	7,878,508	1,100,680	611,135	325,384	5,841,299

Ambulance Service Fees Receivable - Turnover and Days Billings Uncollected

Accounts receivable turnover is one indication of the timeliness of collection. Accounts receivable turnover for Ambulance Service Fees Receivable was 1.00 time for fiscal year 2000/01; 2.2 times for fiscal year 1999/00; 2.5 times for fiscal 1998/99. Accounts receivable turnover for 2000/01 is low as a direct result of delays in producing and mailing billing statements as a result of the paramedic job action.

Days billings uncollected is another indication of the speed of collecting account receivable. 2000/01 - 365 days; 1999/00 - 166 days; 1998/99 - 147 days.

**Collections and Credit Adjustments include all fees paid, and adjustments that reduce indebtedness.

Collection Program Costs

	2000/2001	1999/2000	1998/1999	1997/1998
Collection Dept Costs	\$750,00	\$750,000	\$750,000	\$600,000
Collection & Loan Management Branch	205,000	155,000	175,758	182,000
Collection Agency Commissions	910,056 ¹	499,666	235,164	195,798
Total Collection Costs***	\$1,865,056	\$1,404,666	\$1,160,922	\$977,798

NOTES:

- 1) Private collection agencies were used as of January 2001.
- 2) The Ministry has recognized the increase in accounts receivable for 2000/2001 and has introduced payment plans and will be passing the aged debts to the Collection and Loans Management Branch with the Ministry of Finance.
- 3) Restated balance from 1999/2000.
- 4) Value of current outstanding accounts receivable and total accounts receivable are as a result of the paramedic job action which resulted in a delay for producing and mailing billing statements.
- 5) Total Premiums Receivable have been adjusted to include post closing entries.

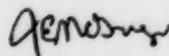
E: MEDICAL SERVICES COMMISSION STATEMENT OF OPERATIONS

MEDICAL SERVICES COMMISSION STATEMENT OF OPERATIONS FOR THE YEAR ENDED MARCH 31, 2001 (UNAUDITED)

(THOUSANDS OF DOLLARS)	2001	2000
EXPENDITURE		
Service Costs	\$	\$
Medical Care	1,965,560	1,807,353
Supplementary Care	127,839	122,943
	2,093,399	1,930,296
Administration		
General Office	6,882	5,969
Salaries	18,012	19,693
	24,894	25,662
	2,118,293	1,955,958
CONTRIBUTIONS (Note 3)		
Premium Revenue	895,601	868,263
Premium Assistance	357,864	362,947
General Contributions	864,828	724,748
	2,118,293	1,955,958

The accompanying notes are an integral part of this financial statement.

Approved on behalf of the Commission:



Janet E. McGregor
DEPUTY CHAIR, MEDICAL SERVICES COMMISSION

MEDICAL SERVICES COMMISSION NOTES TO FINANCIAL STATEMENT

1. THE COMMISSION

The Medical Services Commission was established, effective July 1, 1968, by the Government of the Province of British Columbia under the *Medical Service Act* and Regulations, to administer and operate the Medical Services Plan.

The legal authority for the Medical Services Commission to administer and operate the Medical Services Plan is the *Medicare Protection Act*.

Section 5(4) of the *Medicare Protection Act* states that the *Financial Administration Act* applies to the Commission as though it were a division of the Ministry of Health and Ministry Responsible for Seniors. Medical Services Plan premiums and expenditures are included within the Province's Consolidated Revenue Fund Statement of Revenue and Expenditure, which is audited annually by the Auditor General of British Columbia.

2. SIGNIFICANT ACCOUNTING POLICIES

The Statement of Operations is prepared for the purpose of presenting the expenditures of the Plan and contributions by subscribers and the Province.

The expenditures and contributions are recorded on an accrual basis.

The cost of furniture and equipment is charged to administration expense in the year of acquisition.

The Province of British Columbia pays certain administration, accommodation, data processing and systems salary costs associated with the operation of the Commission.

Service costs include payments for eligible services provided by medical practitioners and other health care practitioners on a fee for service basis according to fee schedules approved by the Commission, and payments on a contract, salaried or sessional basis. The expenditures include estimates of claims, for services performed in the year, that were unrepresented or unprocessed at March 31, 2001.

3. CONTRIBUTIONS

Premium revenue consists of the Medical Services Plan premiums paid by subscribers.

Premium assistance represents the value of subsidy provided by the Province on behalf of eligible persons.

General contributions represent the net amount paid by the Province to fully meet the expenditure of the Commission.

APPENDIX 5 – GLOSSARY OF PERFORMANCE PLANNING AND REPORTING TERMS

ANNUAL PERFORMANCE REPORT:

A ministry document, required by the *Budget Transparency and Accountability Act* (BTAA), to be tabled in the Legislature by June 30 every year. This report may contain information normally found in a traditional annual report, with the additional requirement that a ministry's performance in meeting its goals and targets is emphasized in the document. The document must link directly back to the ministry's performance plan. The annual performance report for 2000/2001 will be the first iteration to replace the traditional annual report style.

BUSINESS AREA:

A set of key activities or programs or budget areas related to the purpose, role and mandate of the ministry. Most ministries will have three to five key business or program areas; larger ministries may have more.

EFFICIENCY MEASURE:

Measuring the relationship between the amount of input (usually dollars or employee years) and the amount of output or outcome of an activity or program.

ENVIRONMENTAL SCAN:

Summary information for critical thinking about, deciding on and preparing a future course of action. An environmental scan assesses the ministry's internal strengths, weaknesses, challenges and opportunities. The scan examines factors within the ministry that can positively or negatively affect its ability to accomplish its mission, goals and objectives. The scan also assesses external forces that significantly affect the ministry.

FULL-TIME EQUIVALENT (FTE):

The equivalent of one person working 1,827 hours in one year.

GOAL:

Goals are the long-term ends that the ministry (or a business or program area) wants to achieve in fulfilling its mandate and mission. Goals must be realistic and achievable.

INPUT MEASURE:

A measure of the amount of resources (dollars and FTEs) used to undertake a function.

MISSION:

The reason for the ministry's existence. The statement identifies what the ministry does, why it does it, and for whom. It also reminds the public and other government entities of the unique purposes promoted and served by the ministry. The ministry's goals, objectives and strategies must be consistent with its mission statement.

OBJECTIVES:

Objectives are concise, realistic, results-oriented statements of what a ministry or program achieves in the short-term on the way to accomplishing its goals. Objectives must be stated in a way that clearly communicates what is to be achieved and measured or assessed, and by when.

OUTCOME MEASURE:

Measuring the results and consequences or changes in conditions, behaviours or attitudes that indicate progress in achieving a program's or ministry's mission and goals. Outcomes may be immediate, ultimate, or somewhere in-between.

OUTPUT MEASURE:

A measure of the level of service provided by a program (i.e., what and how much came out of a program or service). The measurable unit can be a number, percentage or ratio.

PERFORMANCE MEASURE:

A performance measure (sometimes referred to as an indicator) can be used to indicate the degree of success a ministry has in achieving its goals and objectives. When a measure has a specific numeric value attached to one aspect of the performance under consideration, it is then typically referred to as a performance indicator.

PERFORMANCE PLAN:

A plan that describes a ministry's purpose or mission, its direction or vision, its goals and objectives, the operational strategies it will use to achieve those objectives, and how it will know if it has been successful (i.e., through the use of performance measures and targets).

PERFORMANCE TARGET:

Targets express pre-set, quantifiable performance levels to be attained at a future date.

PROGRAM:

A set of activities with clearly defined, dedicated resources and measurable objectives that are coherent and consistent.

RESULT:

A consequence, issue or outcome of an action or series of actions. Often used synonymously with "outcome" and/or "output."

STRATEGIC CONTEXT:

The strategic context of a performance plan provides high-level information that describes where a ministry is now. It usually includes a ministry's vision, mission, values and environmental scan.

STRATEGIC PLAN:

The high-level, government-wide corporate document that outlines the government's vision, mission, values and key priorities for the medium to long term.

STRATEGIES:

Strategies are the actions that describe how objectives are to be achieved. Other terms used to describe strategies are programs, projects, initiatives and activities, among others.

VALUES:

The value statement expresses a ministry's core values or fundamental beliefs. Values define the ministry's management style, organizational values, and code of conduct for personal and organizational behaviour.

VISION:

A clear and compelling picture of a ministry's preferred future – where the ministry is going and where it wants to be. This vision must be sufficiently desirable and challenging to motivate and inspire ministry employees and influence decision-making.

APPENDIX 6 – REGIONAL HEALTH BOARDS

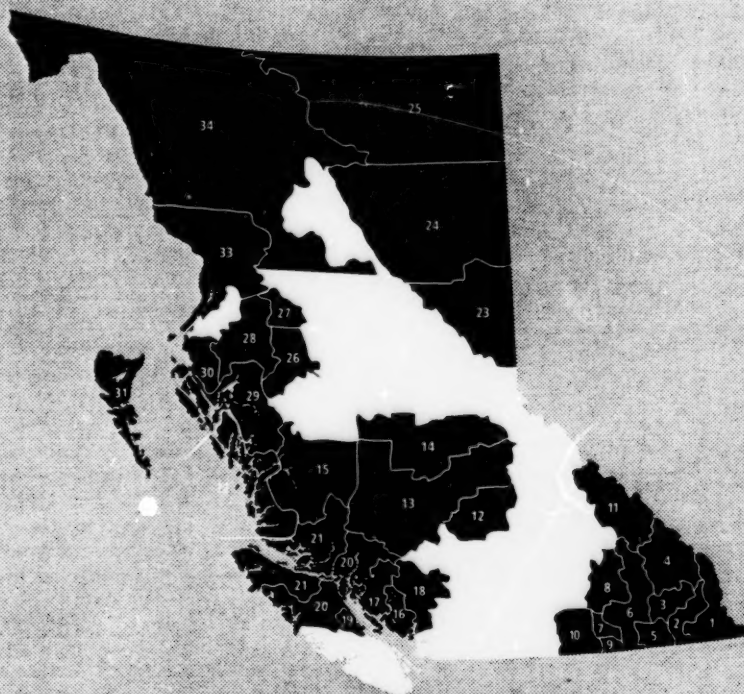


REGIONAL HEALTH BOARDS

1. North Okanagan
2. Okanagan Similkameen
3. Thompson
4. Fraser Valley
5. South Fraser
6. Capital Fraser
7. Central Vancouver Island
8. Northern Interior
9. Vancouver/Richmond
10. North Shore
11. Capital

Prepared by Information and Analysis Branch, Ministry of Health and Ministry, Responsible for Services.
Boundary Source: BC SPPU, Ministry of Planning and Economic Relations.

APPENDIX 7 – COMMUNITY HEALTH COUNCILS

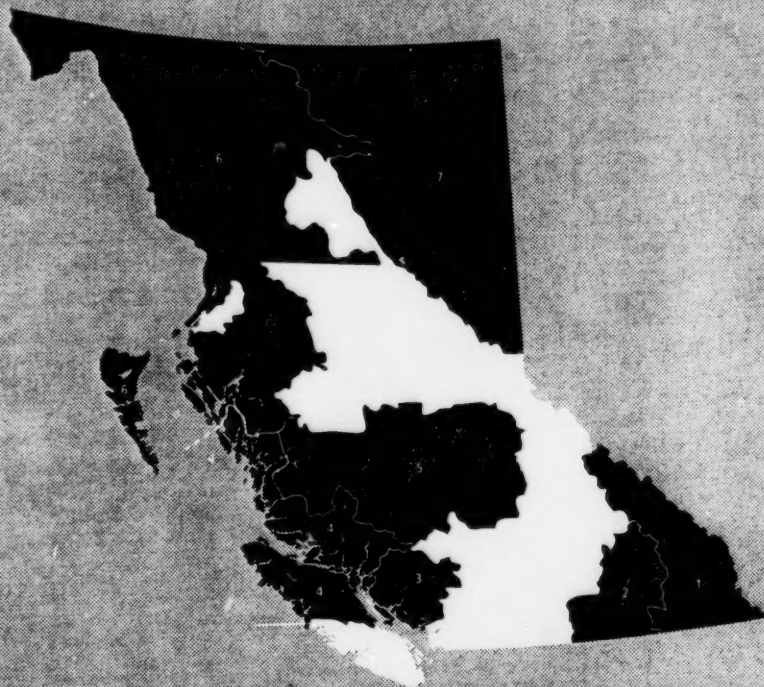


COMMUNITY HEALTH COUNCILS

- | | |
|---|---|
| 1. Elk Valley and South Country | 18. Sea to Sky |
| 2. Cranbrook | 19. Comox Valley |
| 3. Kimberley | 20. Campbell River/Woodka |
| 4. Columbia Valley | 21. Mount Waddington |
| 5. Creston and District | 22. Central Coast Transitional |
| 6. Nelson and Area | 23. South Peace |
| 7. Castlegar and District | 24. North Peace |
| 8. Arrow Lake/Upper Skeena Valley | 25. Fort St. John-Liard |
| 9. Greater Trail | 26. Bulkley Valley |
| 10. Boundary | 27. Upper Skeena |
| 11. Golden | 28. Terrace and Area |
| 12. South Cariboo | 29. Kitimat and Area |
| 13. Central Cariboo-Chilcotin | 30. North Coast |
| 14. Quesnel and District | 31. Queen Charlotte Islands/Vaida Gwaii |
| 15. Bella Coola and District Transitional | 32. Haida's (not designated under the Health Authorities Act) |
| 16. Sunshine Coast | 33. Super Country |
| 17. Powell River | 34. Stikine |

Prepared for Information and Analysis Branch, Ministry of Health and Ministry Responsible for Seniors.
Boundary Source: BC 1997, Ministry of Health and Corporate Relations.

APPENDIX 8 – COMMUNITY HEALTH SERVICES SOCIETIES



COMMUNITY HEALTH SERVICES SOCIETIES

1. East Kootenay
2. Kootenay Boundary
3. Coast Garibaldi
4. Upper Island/Central Coast
5. Cariboo
6. North West (includes Haida)
7. Peace River

Prepared by Information and Analysis Branch, Ministry of Health and Welfare, responsible for health
Boundary Areas of BC, 1985; Ministry of Health and Community Services